THE CANADIAN HOSPITAL

OFFICIAL JOURNAL
CANADIAN HOSPITAL COUNCIL

JANUARY, 1952

MIDWAY HOSPITAL

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Cut laundry costs 54.4%

To assure more absolute control of linens, management of 83-bed Midway Hospital decided to install a compact, AMERICAN 4-Machine Laundry.

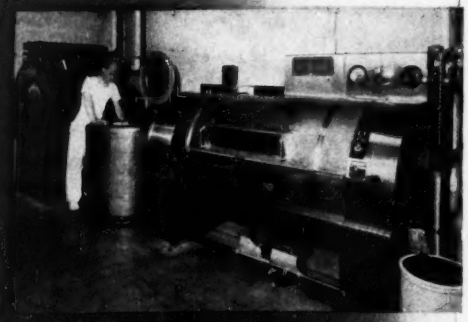
Before the installation, an American Laundry Advisor made a thorough survey of the hospital's clean linen requirements, consulted with the architect and submitted a detailed floor plan layout of the laundry department.

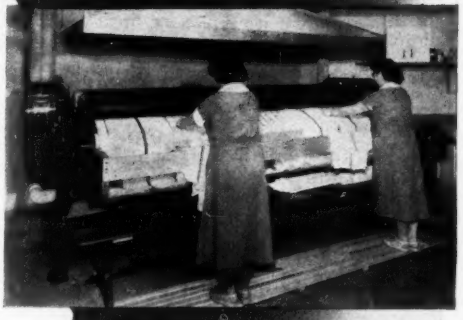
Since installation of the new laundry, the Hospital's Superintendent reports these benefits . . . *laundry costs reduced 54.4%* . . . ability to cope with all linen supply problems, even in event of a major disaster . . . increased departmental efficiency and improved personnel relations throughout the hospital.

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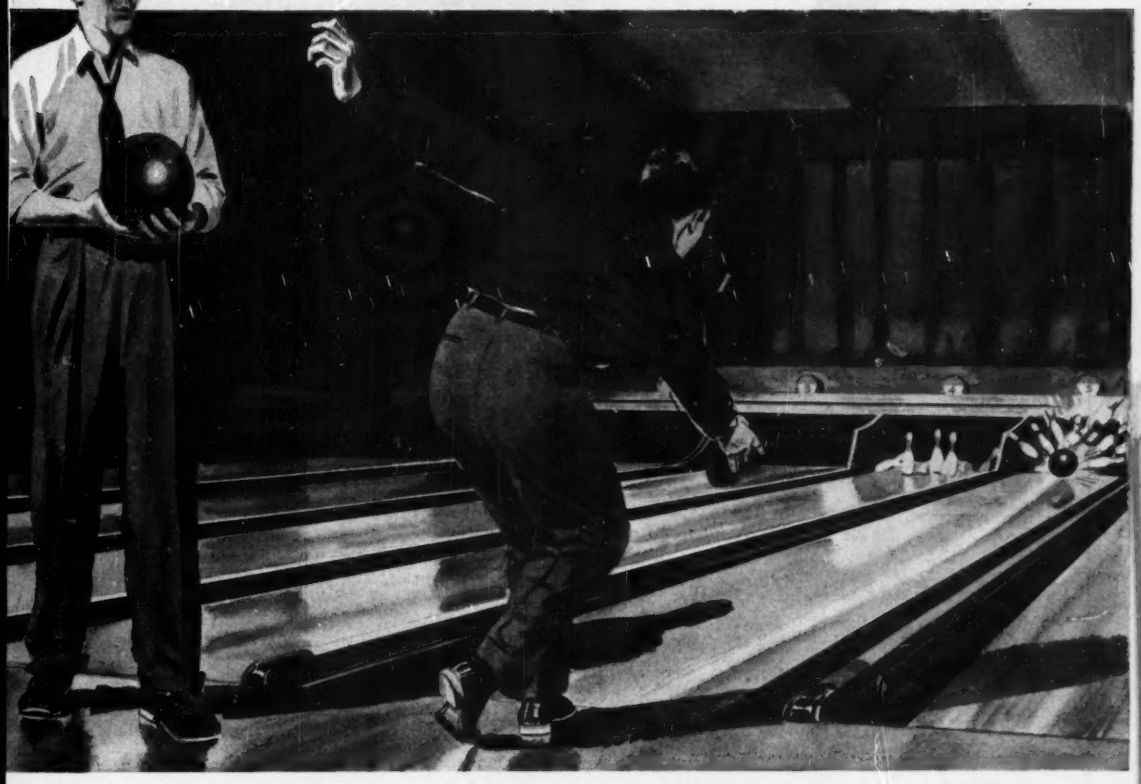
Every Department of Your Hospital Depends on the Laundry.





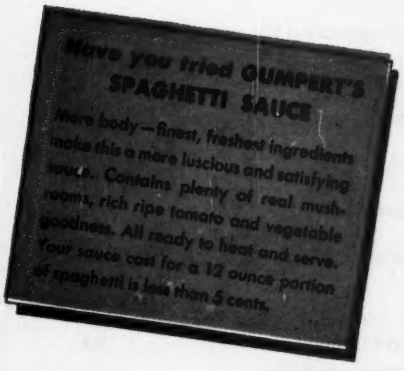
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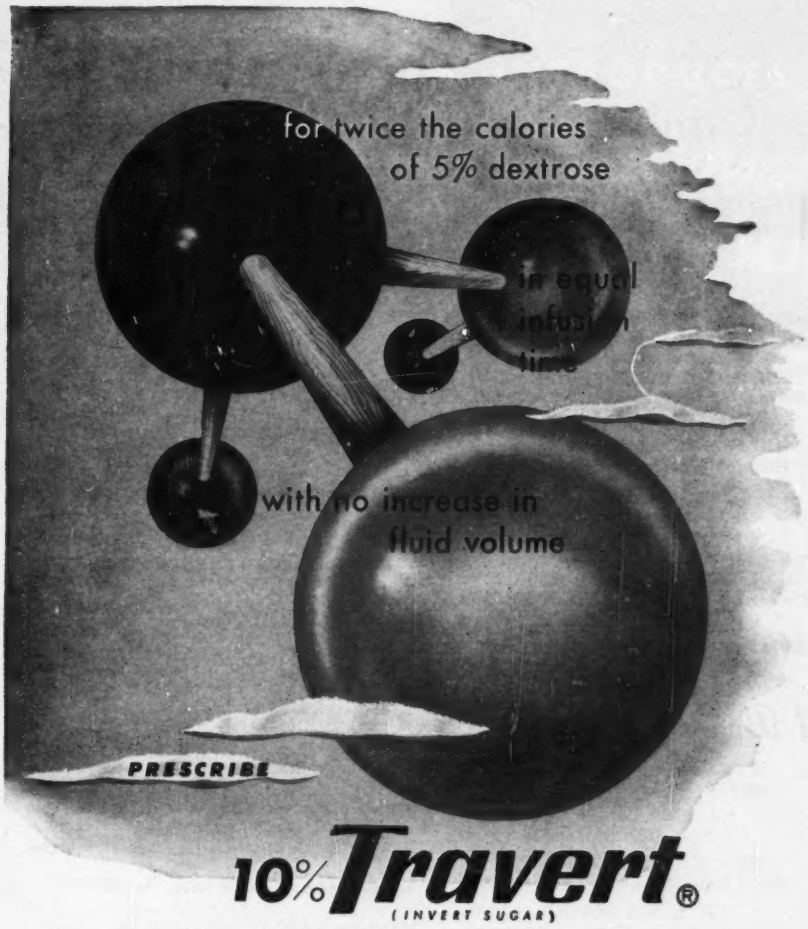
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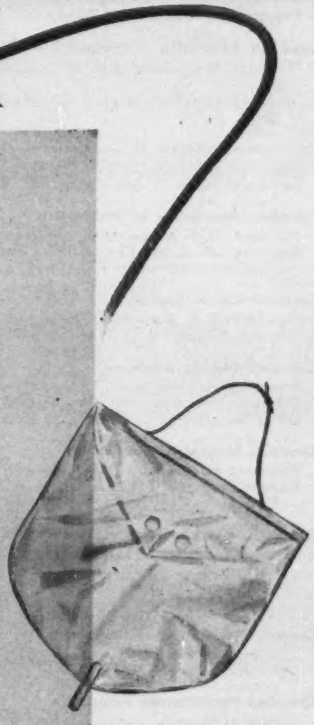
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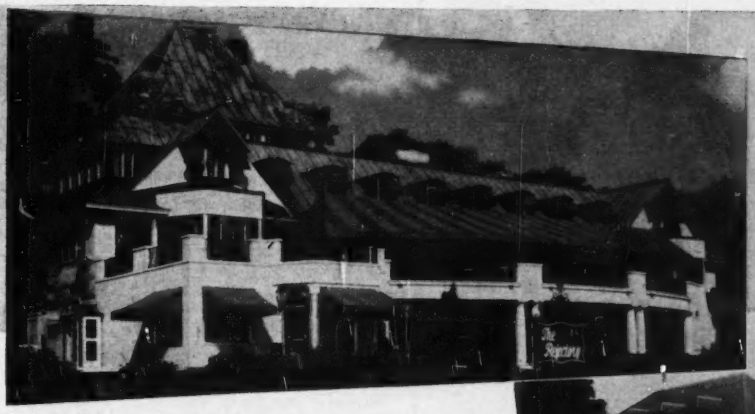
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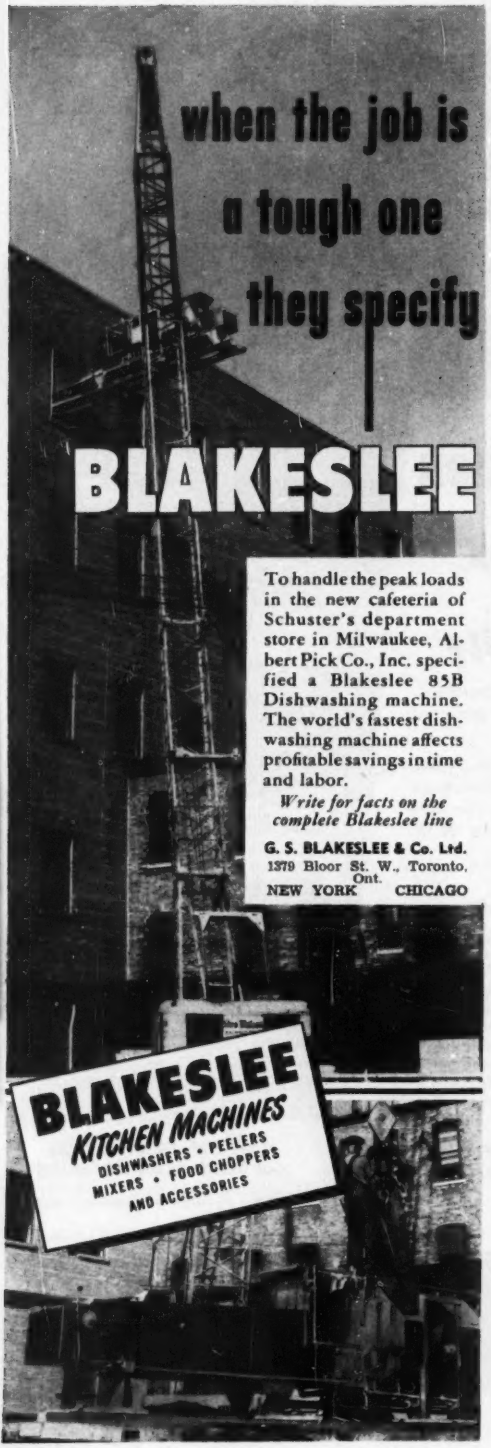
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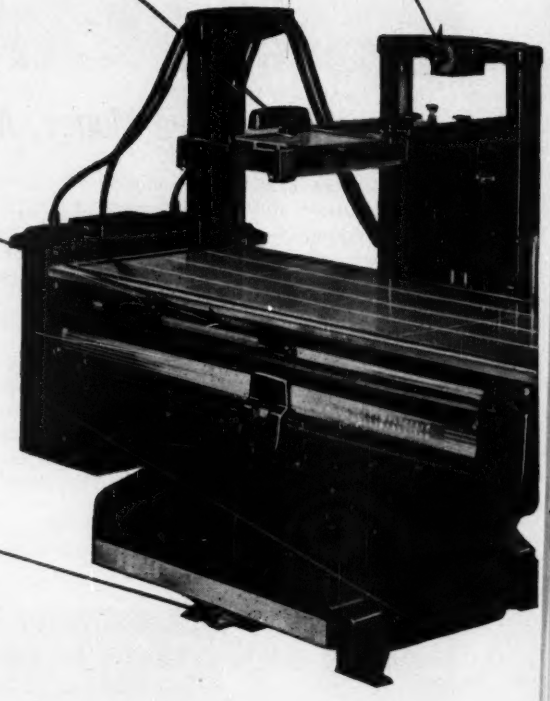
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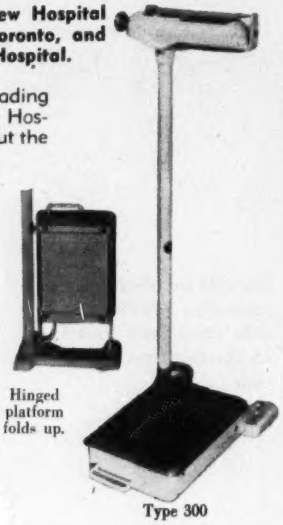
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Across the Desk

(Continued from page 14)

X-Ray and Radium Appointment

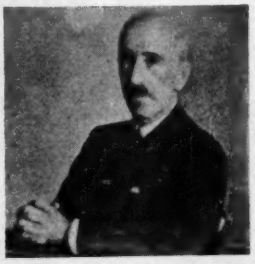


X-Ray and Radium Industries Limited have announced the appointment of Mr. Lionel Fortier to the sales staff of their Montreal office.

Mr. Fortier has had an extremely extensive career in the fields of x-ray and radium. His experience includes technical service with the International Electric Company, and at the University of Montreal assisting Dr. Gendreau in x-ray and radium work. For over two decades he has extended his experience in these fields, specializing in the installation and servicing of x-ray equipment.

* * * *

Mallinckrodt Employees Celebrate Interesting Event



In a recent ceremony at the St. Louis plant of the Mallinckrodt Chemical Works, approximately 1700 employees celebrated the 50th Anniversary in business of Edward Mallinckrodt, Jr., Chairman of the Board.

Mr. Mallinckrodt succeeded his father, Edward Mallinckrodt, Sr., as Chairman of the Board in 1928, and is the second Chairman in the Company's 84 year history. He joined the Company after completing graduate studies for the A.M. degree at Harvard University in 1901 and has been active in the management of the Company's technical as well as business affairs since that time. A chemist in his own right, he is responsible for much of the Company's research and development on ether for anesthesia.

During the ceremony, employees unveiled a portrait of Mr. Mallinckrodt which had been painted by Richard S. Meryman of Dublin, New Hampshire. The portrait had been arranged for through the participation of every one of the Company's 2400 employees throughout the United States and Canada. Charlton MacVeagh, Vice Chairman of the Board, presided at the ceremonies which were attended by the Company's St. Louis employees.

(Concluded on page 22)



This broad group of Terramycin dosage forms constitutes an integrated therapeutic tool for the treatment of a wide range of infections. Depending upon the clinical situation, these specialty forms may be used singly or in combinations, thus providing the optimum in effectiveness, convenience and flexibility of therapy.

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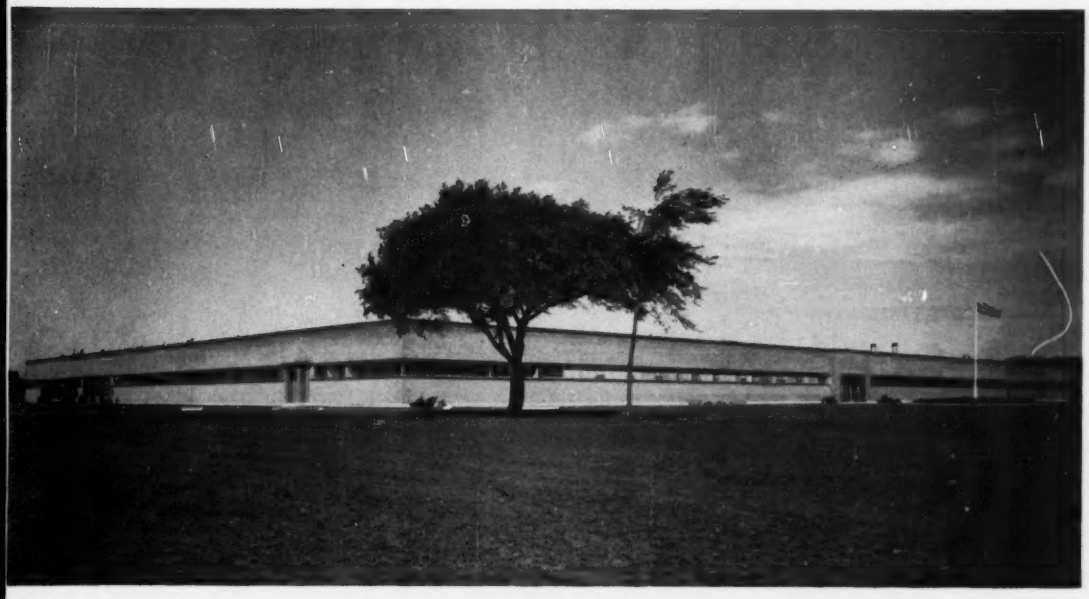
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Across the Desk
(Concluded from page 18)

Ella Skinner Uniforms New Sales Manager



Ella Skinner Uniforms, Toronto, have recently appointed Mr William M. Crago as their Sales Manager. Mr Crago is thoroughly experienced in the uniform field. For the last few years he has been with the Textile Industries of Guelph, where he was in charge of sales of the Uniform Department.

* * * *

Dixie Vortex Water Cup



The Dixie Cup Company (Canada) Limited has added to their lines a 4 oz. Vortex water cup and 7 oz. cold drink cup incorporating the Green Cross and Safety slogans.

The 4 oz. Vortex water cup is printed in "Safety Green" colour and shows the "Green Cross".

The 7 oz. cold drink cup is also specially treated for vending machines. From the standpoint of public relations the safety designs should prove very satisfactory.

* * * *

Hygiene Surgical Incinerator

A new, compact, easy to operate, gas fired Incinerator will soon be imported into the country from England for use in hospitals, nursing homes and clinics. The purpose of the unit is to eliminate the out of date and unhygienic practise of dumping soiled or infected articles in pails or bins.

The largest unit stands only 39" high, and in hospitals, one incinerator per floor, surgical ward or theatre, is recommended. The action of the unit is fully automatic, the burner being ignited by the opening of the door and can be easily operated by anyone. All odours and risk of contamination are completely eliminated.

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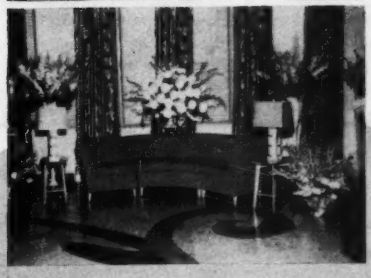
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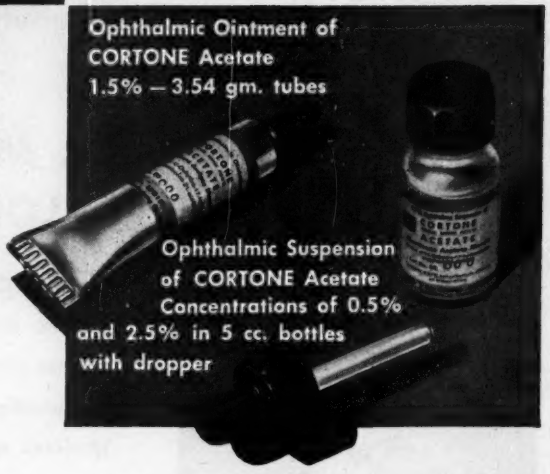
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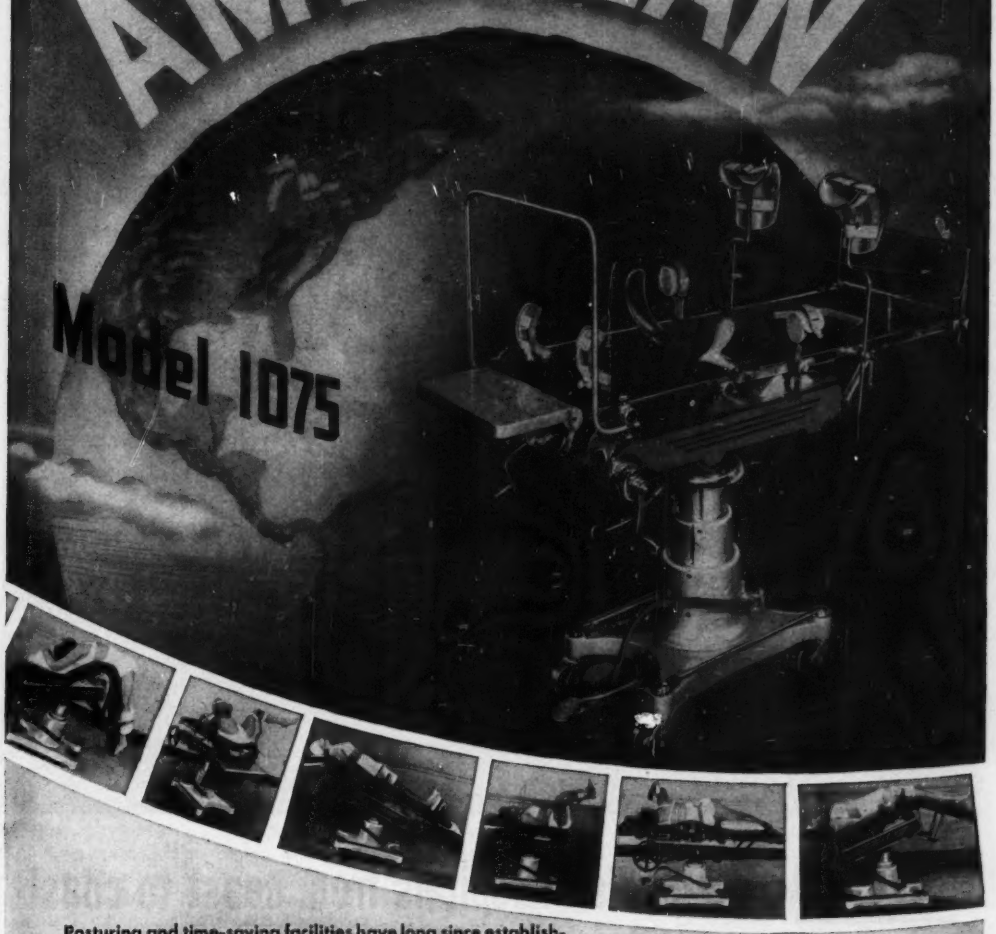
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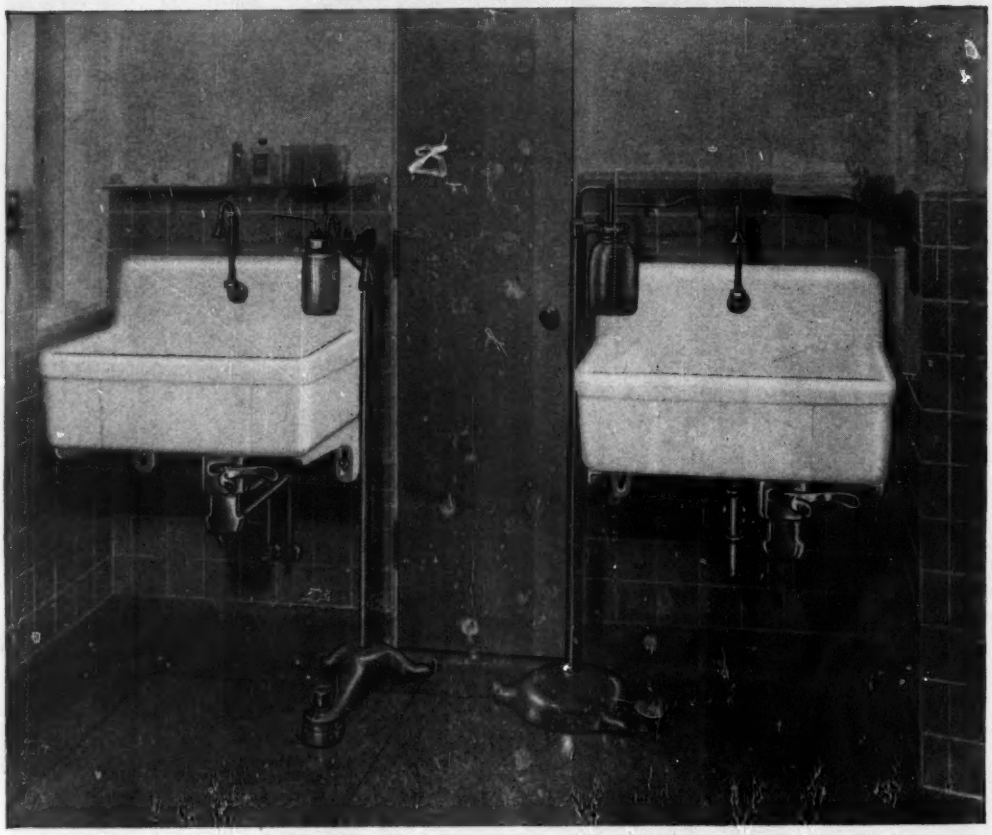
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L. O. Bradley, M.D., Editor

CANADIAN HOSPITAL

Toronto, January, 1952 Vol. 29 No. 1

Obiter Dicta

Where to Treat Communicable Diseases?

ARGUMENTS that acute communicable diseases must be cared for in a separate isolated institution have almost ceased. The health field and the public (more slowly of course) are generally accepting the concept that this group of illnesses can safely be treated in their acute general hospitals. (See *Epidemiology in General Hospitals*, page 29.) There is wider understanding now that it is the function of the acute general hospital to offer its services to all types of acute illness or injuries.

Those who remain unconvinced from a public health point of view are being forced to give way because of relentless, economic pressures. To maintain a separate establishment as a standby service for the isolation of sporadic and intermittent infectious diseases is a costly business. Few municipalities can afford to do so today.

Several good points are made by those who feel that the patient is served better in the acute general hospital. With the modern, small ward layout, equipment and techniques, the chance and frequency of cross-infection is materially reduced. Many hospitals now have an elaborate investigation each time cross-infection occurs, as a means of discipline, education, and of research.

The patient in the acute general hospital has, immediately available, all the resources of the institution—the consulting staff, special departments, and services, et cetera. Because these are at hand, they are used more frequently, which is to the patient's advantage. Another advantage, which is often emphasized, is the importance of training the staffs of the acute general hospitals to care for infectious diseases. When interns and student nurses learn good techniques for this special group of diseases, they are more likely to carry this learning to their work elsewhere in the hospital.

There are a few questions that yet remain to be answered but as experience is gained, techniques and procedures reviewed and revised, and as nursing and medical staffs develop confidence, there will be even fewer. The isolation hospital has served its purpose and very well. It is becoming a monument to medical progress and can now be used to serve other community needs.

Calling All Women

THE nursing bottleneck could be cracked in 1952 if we put our mind to it. Of course, it would not be possible to rustle up an adequate number of nursing personnel within the year but ways and means might be established that would show some real results within a few years. If we can come to grips with the issue this year, it should be in hand in five years.

Most of the work and worrying about the problem and its effects has been done by the small group who are intimately and constantly in touch with the situation. The vast majority of people in the community know little or nothing about nurse shortage and care about as much. Only when a large percentage of the public become concerned about it will anything be done. The problem then is to

make the steadily growing nurse shortage a popular issue so that the community is forced to act.

There is a general belief that nursing is a woman's field and statistics bear this out. Traditionally, nursing care has been given by women in the household and in hospitals or other instiutions and they have discharged their responsibility well. But today there are not enough women in the nursing profession. Thus the quality of nursing care can no longer be maintained. Let the women of the community rally in this emergency and take an active part in solving a grave problem in the field of service that has always been their prime responsibility.

Who then can give leadership so that the women of the community will take up the challenge? The women's hospital auxiliaries come to mind first since they can secure information directly from their own hospitals. They in turn should enlist the aid of other women. The society page of a few newspapers would reveal a long list of national, provincial, and local women's organizations that have a great deal of influence and which could be a tremendous force. Every one of these groups should have a stake in the health field and should be roused to a realization of the need for their assistance.

There are at least a half dozen women's magazines or publications that could do a great public service if they bent to it. However, up to this point, editors have not realized the seriousness of the nurse shortage or its dramatic possibilities as editorial material. (Must news be sensational?) For these reasons, this problem has not commanded the widespread interest it demands. The time is ripe for a few crusading female editors to lead an attack on community lethargy.

The nursing shortage stands as a challenge to women in all walks of life. When they understand that their efforts are needed to nurse the nursing situation back to good health, they will want to do something about it. When enough women become interested and begin to agitate about what needs to be done, you may be certain that those in positions of authority, given their support, will take steps to accomplish something concrete.

Go to it girls—the sooner the better.

A *Cause Advances*

THE announcement by the Winnipeg General Hospital that it has opened a school to train male nurses is a significant step forward (see page 88). The nursing school has a fine reputation and this course should attract a good number of interested and ambitious young men.

It remains now for hospitals across the west to take part in a recruiting program for this course. All hospitals and many other segments of the health field are vitally interested and should support this new program actively. On the basis of this widespread support adequate classes can be enrolled and the acceptance of the idea of men in the nursing field will spread and take root, both in the community and in the minds of men themselves.



—Photo by Dr. A. J. Grace, London, Ont.

"The snow, the beautiful snow, filling the sky and the earth below." —*J. W. Watson*

Epidemiology in General Hospitals

A. C. McGugan, M.D.,
Superintendent,
University of Alberta Hospital,
Edmonton, Alberta.

EPIDEMIOLOGY is the science of communicable diseases, more especially their prime causes, means of propagation, epidemic and endemic manifestations and means of control.

One proposes to borrow an idea from the literature and use the parable of the Sower as a simile to illustrate the whole scope of epidemiology. The subject can be simplified under three headings: The Sower (means of propagation), The Seed (prime causes), and The Soil (the infected or potentially infectable patient). Biologically all forms of life have but one purpose to justify their existence, namely: "To propagate and perpetuate the species". It is the life job of bacteria and viruses to propagate and perpetuate their species just as it is man's job to prevent them from so doing in order that the human species may survive. If one expects to formulate procedures for the prevention of the spread of contagious and infectious diseases in hospitals on a rational basis, he must have some knowledge of the Sower, the Seed, the Seeders and the Soil. The price of infection-free hospitals is constant vigilance and relaxation of that vigilance on the rationalization that the advent of the antibiotics and chemo-therapeutics has enabled medical science to combat infections more competently is an intolerable form of vandalism.

Before we proceed to a more detailed study of our subject, may we spend some time in its introduction. First let us consider:

The Sower

Man is the chief sower of communicable diseases and he constitutes the chief reservoir of infection although animal reservoirs play a part. Man as a source of the spread of communicable diseases may be considered under the following heads:

1. Clinically recognizable cases in the incubation stage, prodromal stage, acute stage, convalescent stage, chronic stage.
2. Sub-Clinical cases—abortive cases, atypical cases.
3. Carriers — convalescent, chronic.
4. Animal reservoirs.

Man is the chief sower of communicable diseases. Today man knows no geographical boundaries and neither do the diseases which he spreads. A typhoid carrier may start out on an automobile trip and in the course of a few days spread typhoid from Louisiana to Alaska. In the course of a few hours an individual suffering from a so-called tropical disease may travel from a Southern Pacific point to the shores of the Arctic Ocean. During the incubation stage (that period of infection from the time of taking in an infective organism to the appearance of the first clinical symptoms) there is little danger of man spreading a disease. A knowledge of average incubation periods of communicable diseases enables the administrator to know when a person may become a menace to his environment if one can get a reliable history of the date of exposure to infection. Although neumonics are sometimes called "crutches for feeble memories" I have always used them in studying and teaching and I propose to continue to do so in this paper.

A convenient way of remembering average incubation periods is as follows:

"D I P S" — Incubation period 1-7 days with an average of 2-4 days.

- D — diphtheria
- I — influenza
- P — plague
- S — scarlet fever

Many other communicable diseases have an incubation period of 7 to 21 days with an average of 10 to 14 days.

The prodromal stage is that period from the onset of symptoms (often febrile) to the appearance of the rash. *It is during this period that most communicable diseases are spread.* As the prodromal period is the most serious from the administrator's point of view a knowledge of its expected duration helps:

Very sick people must take ease						
	varicella	scarlet	pox-small	measles	typhus	enteric
Days—	1-2	2-3	3-4	4-5	5-6	6-7

Isolation precautions are just as important during the prodromal stage as during the acute stage of the disease. For instance whooping cough (pertussis) is quite communicable for several days before the characteristic inspiratory "whoop" is heard. During the *convalescent period* the patient may be a menace to his environment. For example, the scarlet fever case may be considered dangerous for as long as there is a discharging nose, ear or sinus. In the *chronic stage* we think of diseases such as tuberculosis.

Sub-clinical cases are those that are either so mild or so unusual in their manifestations as to escape clinical recognition. During epidemics, poliomyelitis is spread by the mild unrecognized cases.

A *carrier* is an individual who harbours the organism responsible for a communicable disease but who himself does not manifest clinical symptoms. Notable examples of diseases commonly spread by carriers are typhoid fever, poliomyelitis, diptheria, meningitis (meningococcal), scarlet fever and staphylococcal infections.

The hospital management of carriers constitutes one of the most difficult hospital problems in the control of the spread of communicable diseases.

Animal Reservoirs. Although man constitutes the chief reservoir of infection for communicable disease organisms, the lower animals also play a part. In this connection one thinks of such diseases as anthrax, actinomycosis, toenia (tape worms), trichinosis and tetanus.

The Seeders

(Means of Propagation)

Bacteria and viruses leave their animal hosts, whether the host be man or the lower animals, in one of three ways which may be remembered best by thinking of the four "E's":

Egress { Exhalations, Exanthems, Excretions }

Obviously, in order to devise methods for the prevention of the spread of communicable diseases, one must know how each disease is spread.

Many are spread from the upper respiratory tract by exhalation. The control of these diseases lies in the control of the air, masking, and segregation. As an example of *exhalation* spread, one thinks of the community pest with a martyr complex or a work anxiety neurosis who insists on attending his place of work in the acute stage of a cold and who sneezes and coughs in one's face while he expounds upon his devotion to his job and his hardy constitution. As an example of *excreta* spread, from the gastro-intestinal tract, one thinks of typhoid and paratyphoid fever, the dysentries and a host of others. The control of these diseases lies in the care of the hands, the clothes, dishes, excreta, et cetera. *Exanthem* is a skin eruption occurring as a sympton of a general disease. In connection with spread by this means one thinks of the pustules and crustules of small pox, the desquamations of scarlet fever, and the membranous and dermal routes as with venereal diseases and impetigo. Safeguarding one's respiratory route, the hands, clothes and environment generally, is indicated in these diseases.

Disease producing bacteria and viruses are spread *directly* by the droplet method, e.g., tuberculosis; and *indirectly* by the three "F's"—food, fingers, flies,—from excreta to susceptible contacts. Insects also play an important part in carrying germs from host to victim. The insect may act as a vector (malaria) or as a mechanical carrier (typhoid and dysentries).

The Soil

(The Susceptible Individual)

Disease-producing bacteria and viruses gain access to the human body in three ways which may be remembered by remembering the four "I's", namely:

Ingress { Inhalation, Ingestion, Inoculation }

When one thinks of ingress by *inhalation* he thinks of such diseases as pneumonia, tuberculosis, diptheria and whooping cough. Ingress by *ingestion* is exemplified by such conditions as food poisoning and food infection, typhoid fever and the dysentries. *Inoculation* ingress is typified in such diseases as malaria, impetigo, venereal diseases and pyogenic infections generally.

Whether or not the soil is to be productive depends upon the individual's immunity. Immunology is a vast subject on which many volumes have been written. For our purposes a brief elementary discussion of the subject will be sufficient.

Immunity may be non-specific or specific. Non-specific immunity depends upon the individual's general health. Hospital patients usually are in a weakened condition and their non-specific resistance is low. Specific resistance to disease may be acquired naturally or artificially. We acquire immunity naturally by having had a disease or by having been exposed to repeated doses of the seed of that disease. The seed of a disease may be bacteria, viruses, toxins, et cetera. These act as antigens (factors which stimulate the production of antibodies) and these antigens stimulate the production of antibodies such as antitoxins which provide varying degrees of specific immunity. We may also acquire immunity artificially. We may have such products as toxins and bacteria in weakened forms introduced into our systems. These act as antigens to produce antibodies which give us a more or less permanent *active* immunity to a disease. We may have antitoxins which have been produced in other animals introduced into our bodies. These give a more or less transient *passive* immunity.

Obviously, members of our hospital staff, particularly nurses, should be immunized to the degree possible against diptheria, scarlet fever, typhoid and paratyphoid fever, tuberculosis, whooping cough and such other diseases as from time to time appear to be indicated; and general non-specific resistance should be maintained to the degree possible by avoiding excesses in work and play. The soil in hospital patients is indeed a fertile field. Debilitated patients, open wounds, the parturient uterus with its rich blood supply, the lactating breast, and the tender skin of infants, all demand the utmost care and protection against infecting organisms.

The Seed

When one thinks of hospital infections he thinks first of the pyogenic (pus-forming) infections caused primarily by staphylococci and streptococci. These may be harboured by their hosts (either as cases or carriers) and the prevention of their transmission is a problem of prime importance in the hospital. To classify or identify the members of these

(Concluded on page 74)



Students entertain visitors in one of the several reception rooms.

The St. Elizabeth School of Nursing

STUDENTS and nurses at St. Joseph's Hospital, Sudbury, Ont., may be proud, indeed, of their handsome new nurses' residence and training school—the St. Elizabeth School of Nursing. The $1,250,000 residence which has accommodation for 120 students and graduate nurses is another accomplishment of the Grey Nuns of the Cross. Designed by P. J. O'Gorman, architect, Sudbury, the eight-storey, fire-resistant building is of reinforced concrete, with yellow brick facing. It is adjacent to the hospital and, being situated on elevated ground, commands an imposing view of the city and surrounding area. A tunnel connects the residence with the hospital.

Modern, attractive furniture gives a streamlined appearance to the main floor reception lobby, which is faced with green Italian travertine. The information desk and switchboard are located here and an elevator conveys passengers to all other floors. The main floor also provides space for several small reception rooms where student may receive guests.

The school of nursing occupies the main floor, along with the administrative unit, and is comprised of two lecture rooms, a library, and nursing arts, chemistry, and dietetic laboratories. Glass blocks are used extensively to assist in day-lighting the classrooms. A combined gymnasium and auditorium, with a seating capacity of 500, provides recreational facilities for the students. Here, they may enjoy table tennis, badminton, basketball, volley ball, and dancing. It will also be used for teas and receptions. Outside tennis courts will afford another source of recreational activity for the warmer months.

Lockers, a lounge, and a kitchenette have been provided for graduate nurses not living in residence. The building also contains a sewing room, sorting room, maids' rest room, mimeographing room, storage room, kitchenettes, rumpus room, and a beauty parlor.

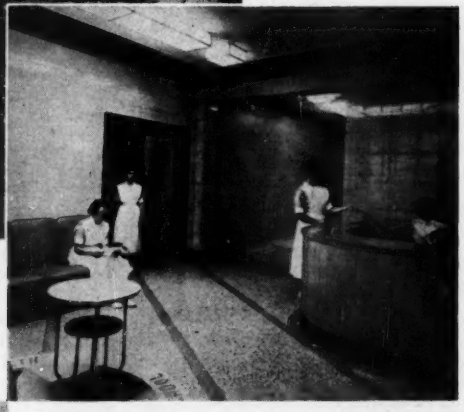
Living accommodations are provided for the nurses in the six upper storeys. Each room is private and contains a bed with an inner spring mattress, a dresser, desk, easy chair, study lamp, bed lamp, running water, and an intercommunication system. Furniture is coloured in a silver mist and natural maple metal and gives a soft tone to the rooms against varied backgrounds of peach, blue, green or yellow walls, drapes, and spreads. A spacious bathroom on each floor is well-equipped with showers and baths. Red quarry tile floors add colour to the solarium on each floor. Furniture is in tan leatherette and wood, giving a natural finish throughout. A roof sun deck, which is protected by a guard rail, will be much appreciated in the summer months.

Attention to many details such as layout, design, and colour scheme, has made the St. Elizabeth School of Nursing comfortable, home-like, and functional.

(See next page for illustrations)



St. Elizabeth School of Nursing, Sudbury, Ontario.





Above Left: Erect and tall, the graceful exterior of the St. Elizabeth School of Nursing, Sudbury, rises above the surrounding residential district.

Above Right: Reception lobby affords first glimpse of the well-appointed interior. A circular mosaic design, on the terrazzo floor, bears the school's title.

Left: The dietetic laboratory provides students with practical experience in the culinary art. All photos through the courtesy of "The Sudbury Daily Star."

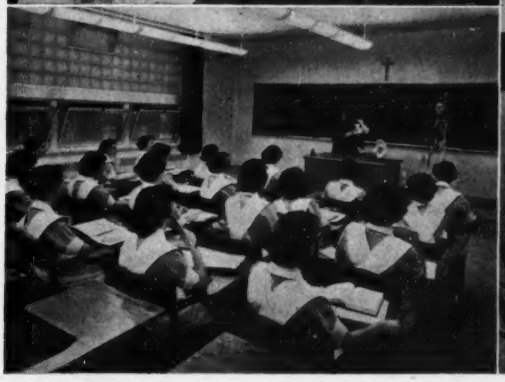




Views shown here, clockwise, beginning above left: (1) A popular student meeting place is one of the eight solaria, which have glare-glass windows. (2) Private bed-rooms are comfortable, spacious, and attractively decorated. (3) A bronze school crest lends dignity to the white stone entrance. (4) The library, furnished in maple, contains books for study and recreation. (5) Students find lessons enjoyable in this bright new classroom. (6) Leather-cushioned sofas and chairs and a marble fire-place add to the cosy atmosphere of the drawing room.









Civil Defence Planning in High Gear

L. O. Bradley, M.D.

THE YEAR 1952 will go down in history as the year that Canada's Civil Defence Casualty Service program shifted into high gear. Phase I of the action program is to be completed on schedule, that is, June 30, 1952, and phase II should be well under way by then. Hundreds of first aid teams and stations are to be ready for any emergency; more than 1,000 hospitals will have prepared their disaster plans, and many hundreds of thousands of trained personnel will be standing by. However, before all this can be read into the record, Canada must have the support of every Canadian in the health field.

Now that civil defence authorities have nearly completed their basic preparations, hospitals can stop waiting and wondering when they can get on with their civil defence programs. The time has come for them to swing into action, as individuals and as a group.

Because many hospitals have a strong sense of duty concerning civil defence, there have been frequent questions about the length of time taken to get the civil defence program started. The interval that has passed since the first mention of civil defence may seem long but, in reality, it has been time well spent.

The basic concept of civil defence is local preparedness, supported by mutual aid. In the event of atomic explosion, no city will be sturdy enough to stand alone, even with the most elaborate of local preparations. The victim will need immediate and sustained assistance from its neighbors, far and near. Thousands of lives may be saved if the perimeter help can be integrated with a well developed preparedness program within the target city itself.

How can this be done? Sound organization is the key as it is with any major project. Thus, it was first necessary to set up a federal organization to begin the work of standardization. As personnel needs were determined, training programs had to be planned, curricula built, schools established, texts written, instructional staff taught, and so on. Research was done on first aid kits and hospital supply schedules.

Then the provincial civil defence organizations were developed with standards for this level. Next, action was initiated at the local level although this phase has lagged seriously in some areas. With the framework almost completed the time has come to fill it in with staff and equipment. This is the point at which the action program becomes effective.

It is of primary concern that our hospitals be ready to meet their responsibilities if disaster strikes. To help them achieve standardization in planning, a "hospital survey-planning kit" has been prepared and is being distributed to hospitals early this year. This kit, containing various forms, is to be used as a guide in surveying facilities and drawing up a plan for each area of the hospital. Both survey and planning should be carried out by a team composed of representatives from the medical, nursing, and administrative staffs and specialists from other departments when necessary (dietitians, engineers, et cetera). Teamwork during the planning phase facilitates teamwork when an emergency calls for action.

To be used in conjunction with the survey planning kit is a special booklet on the hospital's role in civil defence that is being reprinted from the larger *Civil Defence Health Services Manual*. With these two guides, each unit can prepare its own disaster plan, make its staff familiar with the plan, recruit and train volunteers, draw plans or ward charts, assemble telephone lists, et cetera. Basic information on expanded bed capacity, surgical teams, nursing teams, et cetera, can be furnished readily to the provincial civil defence health director (usually a member of the department of health). In this way, the whole provincial preparedness program can be integrated and co-ordinated.

Hospitals can begin at once to carry out individual surveys. There is little enough time to do this and to build a good plan before June 30, 1952. As soon as the basic organization is outlined, attention can be turned to recruitment and training of staff.

All hospitals will not need an elaborate plan for civil defence for some may be far from an attractive target; *but* every hospital should have a good idea of its capacity to handle any large-scale disaster that may ravage its community, whether it be flood, fire, train or plane crash, or industrial explosion.

Your provincial hospital association, in co-operation with the provincial civil defence health authority, will define the part of each hospital in the provincial and national scheme. If there is no action—agitate!

Government, which has the prime responsibility of protecting its citizens, has not found it easy to stir the community into activity and participation. Voluntary agencies at all levels can again be the vital spark in this new program. The enthusiastic support of voluntary effort will give it the life that it needs. It is our turn now.

Western Canada Institute

The seventh Western Canada Institute for Hospital Administrators and Trustees will be held this year on the campus of the University of British Columbia, Vancouver, B.C., June 16 - 20. Accommodation will be available in university residences.

The Horizon of Chronic Illness

Pearl L. Morrison,
Superintendent,
The Queen Elizabeth Hospital,
Toronto, Ont.

WHY horizon? To quote Tennyson in *Ulysses*, "all experience is an arch, where through gleams that untravelled world, whose margin fades forever and forever as I move." The poet's imagery, I feel, may well be applied to the crying need for more accommodation for chronically ill patients. The margin or horizon of this problem "fades forever" as we move closer to it—the more beds we provide, the more we see are needed. Due to present housing conditions, increased life span (and illness in later years is more difficult to shake off quickly), more and more beds are demanded. Those who are interested in beds for the acutely ill continue to draw attention by stating how many more acutely ill patients could be accommodated in one hospital bed, if only there were chronic beds available. I would like to ask the question: When does *a* bed become *many* beds, wherever it may be? Only one patient can use a bed at one time —anywhere. The acute hospital wants a chronic hospital bed so that there will be one available, quite unmindful of the fact that the chronic bed can only be filled once—in a long period. It too must be emptied in turn before it can be filled again. Where are these chronic patients to go? That is the question to be answered.

From an address presented at the Women's Auxiliaries section meeting, Ontario Hospital Association convention, Toronto, October, 1951.

It is an integral part of clinical, non-institutional, and community responsibility to meet the problem of chronic illness. Such a few years ago, this type of illness was relegated to a back corner, of interest to the few whose lives were actually involved, such as the immediate family, and sometimes not even family. Everyone was guilty. Now, because of the pressure of numbers, the study of treatment and care can no longer be sidetracked. These patients are taking up too much space to remain obscure.



Patients at The Queen Elizabeth Hospital enjoy fresh air and sunshine.

Our horizon again eludes us as our arch widens, revealing more and more to do to alleviate this growing problem of extended illness. We must find what is best for these unfortunate patients who are ill so long that they have lost their daily contacts, such as a job, and often their homes as well. We can no longer just leave them, we must do something about returning them to normal living and to a new vocation if necessary.

Chronic illness is not only an old age problem. Young and old alike become ill for long periods of time and need care and rehabilitation. Many chronic diseases such as poliomyelitis, rheumatic fever, heart disease, and diabetes, characteristically occur in childhood or early adult life. Accidents happen frequently to teen-agers and young adults (because they are so active in both work and play), often causing years of hospital treatment. However, among those who are not so young and have less vitality to throw off illness of any kind, there is a greater proportion of long-term patients.

For all, we need a rehabilitation program designed to enable the individual who is physically disabled, chronically ill, or convalescing, to live and work to the full extent of his capacity; or we must prepare him to live with his illness or handicap, gracefully.

There is no illness of the body which does not have some influence on the mind as well. To treat the body suffering from extended illness and neglect the need of the mind is most unfortunate. A blank mind is an impossibility. It is, therefore, necessary to fill the mind with thoughts of cheerful living if we wish to refresh the body. This is where official visitors, appointed by womens' auxiliaries, come in for good or—the opposite.

There are so-called hospital visitors who think that a visit

(Continued on page 78)

Special Reports for Cost Control

David H. Spanier,
Hospital Accounting Consultant, Division of Medical and Hospital Resources, Public Health Service, Washington, D.C.

THE CO-ORDINATION and efficiency of internal departmental operations in hospitals can be greatly improved if administrative heads of departments and hospital administrators are furnished currently with such special reports as will best emphasize cost control and provide analyses of accounts which may disclose waste, inefficiency, and poor supervision. Hospital administrators, especially those not trained in accounting, may not know what special reports the business office can furnish, therefore, no requests for them may ever reach the hospital accountant.

Bad Debts Charged Off

To obtain such managerial aids as the business office is in a position to furnish, administrators should request reports of a special nature, such as "Bad Debts Charged Off", classified by physician or "Purchase Discount Lost". There will come to mind many more special or unusual reports which management may utilize as a form of control technique or to evaluate departmental operating efficiency and economy.

Form A illustrates one method of classifying bad debts for a six months' period by name of physician. Provision is made thereon for obtaining a subtotal for each doctor and a grand total for all doctors. Such information is readily available from the accounts receivable records in the business office.

Conventional methods of classifying bad debts are useful to the business office in determining when the accounts should be placed in the hands of a collection agency or referred to an attorney for collection. However, the classification method shown by Form A will provide management with one convenient technique for obtaining a list of doctors whose patients are slow in paying; and will give a method of obtaining assistance in collecting accounts from such patients. When this situation is called to the attention of the doctors, they may offer to help the hospital by suggesting that their patients make the necessary arrangements for payment of bills before they are hospitalized.

Purchase Discounts Lost

Another management aid is a list of purchase discounts lost. When we consider that 40 cents of each dollar spent for hospital operation is for supplies, materials, food, and equipment, the amount of purchase discounts in a year can add up to a considerable sum.

Form B illustrates one way of listing purchase discounts lost by name of creditor. A cursory examination of such a list will tell at a glance the amount of discount lost on each purchase, arranged in order by name of creditor. It is important that a special report, such as this, contain facts at a glance and provide an administrator with control methods to safeguard hospital assets and provide greater economy in operation.

Analysis of Late Charges

A large percentage of patient income is represented by patients' accounts receivable. Frequently, some hospital charges which were received in the business office af-

From an address presented at the accounting section, Ontario Hospital Association convention, Toronto, October 1951.

Form A

Bad Debts Charged Off

(Classified by Physician)

For the six month period ended June 30, 1951

Name of Physician	Name of Patient	Amount of Bad Debts
Dr. L. M. Curem	Allen, J. L.	$200.00
	Budde, T. R.	75.00
	Cort, Jack	60.00
	Sub-Total (for each doctor)	$335.00
Dr. V. G. Diagnosis	_____	_____
	_____	_____
	_____	_____
	Grand Total	$1,845.00

Form B

Purchase Discounts Lost for June, 1951

Paid to	Amount of Check	Amount of Purchase Discount Not Taken
Abbott Grocery Co.	$257.12	2.10
Brown Hospital Supply Co.	318.00	6.36
_____	_____	_____
_____	_____	_____
_____	_____	_____
Total	4,615.00	$64.12
Total Discount Taken		$27.09

ter the discharge of the patient are not shown on the patient's statement. An analysis of such late charges, indicating the name of the patient, the department whence the charges originated, and the amount of each charge, would reveal at once the department responsible. Thus the administrator can take prompt remedial action in order to prevent such an occurrence in the future.

Form C is an analysis of late charges for the month of June, 1951. In addition, the form contains sufficient space for a summary of late charges by departments.

Personnel Turnover

Daily and periodic reports from department are among the most useful instruments at the command of the administrator both as a means of keeping him informed on the internal affairs of the hospital and in pointing up details to be observed in his routine rounds of the hospital. Such a report is that showing personnel utilization and turnover.

From these reports, a summary for a specific period may be prepared, as demonstrated in Form D, wherein a complete record of personnel turnover by department is presented for a six months period. Comparison with similar reports for other six months periods will disclose differences which should be further investigated. Personnel utilization should go hand in hand with that of hospital services and facilities. Therefore, comparisons of service and facility utilization will indicate whether or not there has been a corresponding increase or decrease in personnel utilization. The frequency with which such comparisons should be made must be left to the judgment of the administrator and to his knowledge of the statistical data revealing fluctuations in patient occupancy and hospital service utilization of sufficient proportion to accelerate the rate of employee turnover.

On the form illustrated, the percentage of turnover is also indicated. This percentage is computed by dividing the total number of employee resignations and discharges by the number of employees at the beginning of this period.

Slow Moving Inventory Items

Because of the nature of hospital operations, it is necessary that hundreds of supply items be carried in inventories to provide ample stocks for day-to-day use. Because of substantial price reductions resulting from quantity purchases, many hospitals find it more economical to purchase some supply items in quantities sufficient to take care of their requirements for several months. However, because of spoilage and deterioration, it sometimes happens that certain items cannot be used after 30 days.

It is for the purpose of bringing to the attention of administrators and department heads those items which are either in too great a supply for use in the near future or are perishable and require prompt use that Form E was designed.

Indigent In-Patients

It is sometimes thought that indigent in-patients in a hospital are provided with more special services than are paying patients. Some are of the opinion that physicians of indigent patients may order certain minor laboratory tests for such patients in cases where they would make these tests themselves for paying patients. This is done on the theory, perhaps, that since doctors may receive no pay for their services, the hospital should contribute equally to the care of the indigent.

Form F provides a ready basis for analyzing the special services rendered to indigent in-patients and for comparing the services

(Concluded on page 86)

Form C

Analysis of Late Charges For June, 1951

Name of Patient	Originating Department	Amount of Charge
John Doakes	Laboratory	$7.50
Leslie Normal	Pharmacy	1.75
	Total	$45.20

Summary—By Departments

Department	No. of Late Charges	Total
Laboratory	4	15.20
Pharmacy	7	16.25
Total	21	$45.20

Form D

Personnel Turnover for a Six Month Period

Department	Number of Employees: At Beginning of Period	At End of Period	Resigned During Period	Discharged During Period	Total Resigned and Discharged	Percentage of Turnover
Administration	6	6	2	2	4	66.7
Dietary	14	12	1	1	2	14.3
	—	—	—	—	—	—
	—	—	—	—	—	—
Total	146	140	21	13	34	23.3



For Long-Term Patients

St. Mary's Hospital, London, Ont.

ON MAY 1, 1951, another step forward in the care of the chronically ill was taken in London, Ontario, as the modern, new St. Mary's Hospital was officially opened. Within its walls, 211 long-term patients receive scientific treatment and care in surroundings which emphasize comfort, convenience, and cheer.

Conveniently located opposite St. Joseph's General Hospital, St. Mary's is also joined by a connecting wing to the House of Providence (an old people's home). All three institutions are operated by the Sisters of St. Joseph. St. Mary's and St. Joseph's hospitals have the same governing board and medical staff but separate administrative staffs. This arrangement has many advantages, especially in teaching both student nurses and interns.

Commanding an imposing view of London, the "Forest City", St. Mary's is a six-storey building of steel and reinforced concrete construction. The exterior is of buff brick and stone facing, while the entrance of black granite features large plate glass doors, encased by stainless steel. Architects were John M. Watt, F.R.A.I.C., and Peter Tillmann, M.R.A.I.C. London.

Throughout the hospital, construction, design, furnishings, and decoration have been planned with the requirements of the long-term patient in mind. Thus the colours which are used produce a soft and restful effect; rose, yellow, blue, and green are found in the various wards and rooms, while blue carpeting covers all corridors. Lighting throughout the building is incandescent and various types of fixtures have been installed. In the corridors, the specially designed fixtures

One side of a four-bed ward and a glimpse of a gaily decorated lounge.







Opening day flowers add an extra touch to the decorative scheme which features colourful drapes, graceful furniture, and interesting floor design.

give correct lighting and at the same time fit in with the decorative scheme. In the solaria, all lighting is recessed to play its specific part in the primary plan of the hospital—to bring comfort to the aged and ailing. Much of the furniture is in natural colouring and is modern and comfortable. Bright drapes add a touch of gaiety to patients' rooms and solaria.

The solaria are located at the end of each corridor and are large and bright with windows opening on three sides to give a magnificent view of the hospital gardens and lawns. A sun deck is located on the third floor.

To help eliminate noise, there are acoustic tile ceilings, rubber tile and linoleum floor coverings, and noiseless light switches. Even the signal system in use at the hospital has a quiet, soft sound.

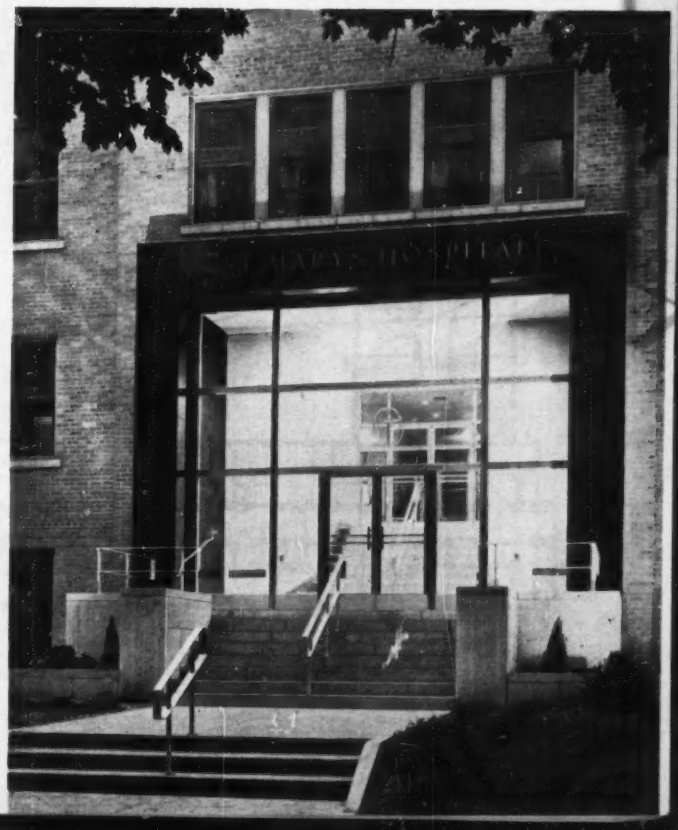
Treatment facilities at St. Mary's Hospital include occupational and physical therapy as well as hydrotherapy. Treatment with short wave, infra red and ultra violet rays is provided; and the hydrotherapy department contains a whirlpool bath, arm and leg immersion bath, wax bath, and sitz bath.

Patients are accommodated in 39 four-bed wards, 24 private rooms, and 12 semi-private rooms which are located on the first, second, third and fourth floors. The sisters occupy the top floor.

The nurses' station on each floor is centrally located and near elevators. As further conveniences to patients the nurses' call system extends to solaria, bathrooms, and toilets; and an "invalift" in one bathroom on each floor makes it possible for many helpless patients to have the comfort of a tub bath. There is also running water in every patient room.

A large chapel is located on the second floor and an oratory on the main corridor of the fourth floor. The chapel has a lovely rose-coloured sanctuary and altar, with furnishings in natural colour. At the back of the chapel, there is a space to accommodate wheel chairs.

The large, bright, modern kitchen is on the ground floor. The dietetic department includes a deep freeze, walk-in refrigerators, a bake room, and dishwashing room. Heated conveyors are used to bring food to each floor. A cafeteria with a seating capacity of 100 has been provided for the staff. St. Mary's kitchen also sup-

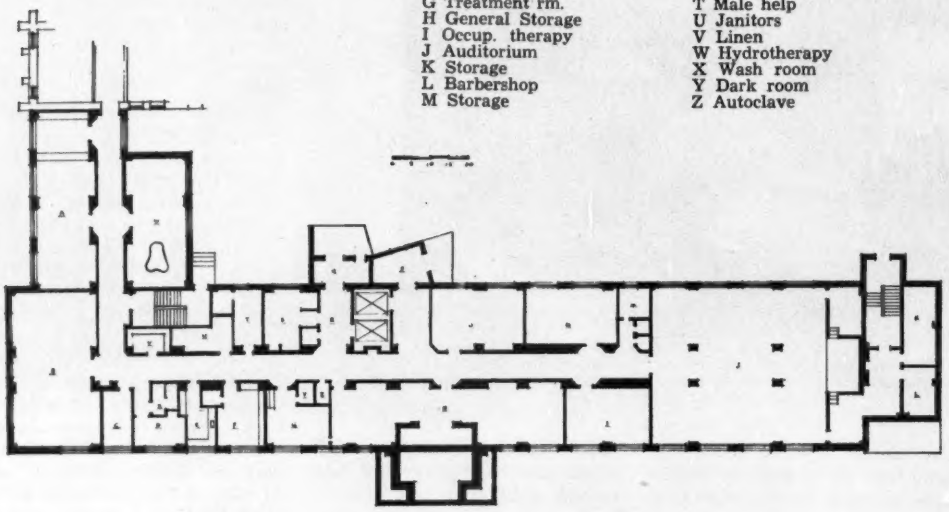


Architects:
John M. Watt,
Peter Tillman,
London.

Ground Floor

Legend

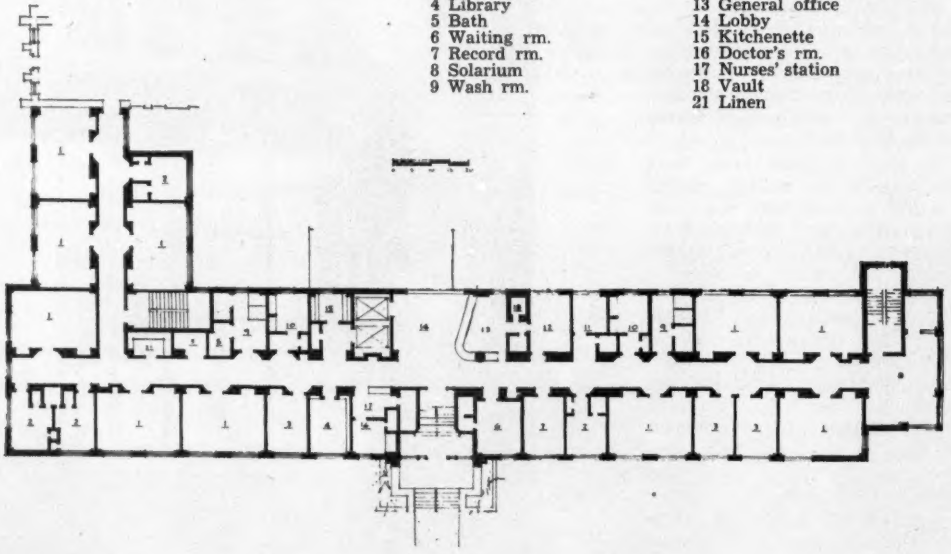
A Cafeteria
B Physiotherapy
C Dentist
D Admitting bath
E Laboratory
F Female help
G Treatment rm.
H General Storage
I Occup. therapy
J Auditorium
K Storage
L Barbershop
M Storage
N Lecture
O Sewing rm.
P Amblance ent.
Q Service ent.
R Service lobby
S Morgue
T Male help
U Janitors
V Linen
W Hydrotherapy
X Wash room
Y Dark room
Z Autoclave



First Floor

Legend

1 4-bed ward
2 Private rm.
3 Semi-private
4 Library
5 Bath
6 Waiting rm.
7 Record rm.
8 Solarium
9 Wash rm.
10 Utility
11 Treatment rm.
12 Superintendent's office
13 General office
14 Lobby
15 Kitchenette
16 Doctor's rm.
17 Nurses' station
18 Vault
21 Linen



plies food for the House of Providence.

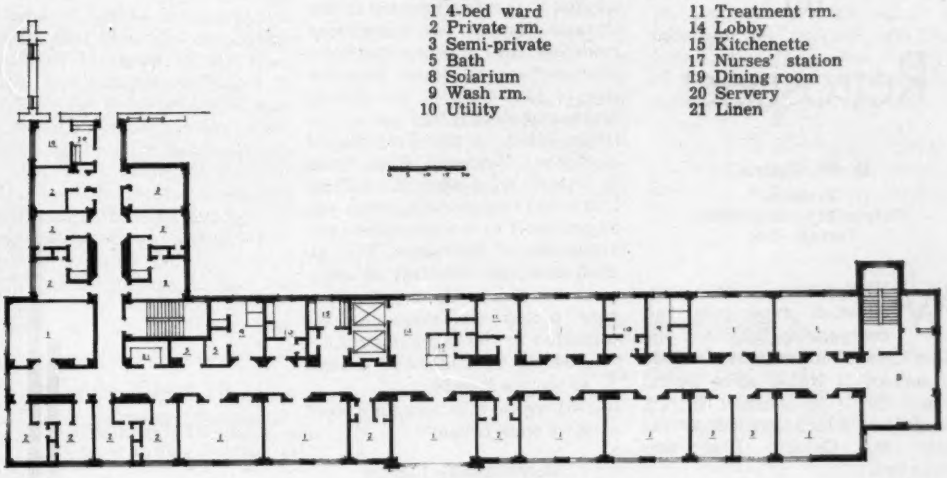
To give added service and comfort to patients, St. Mary's Hospital likewise contains a dental clinic, beauty parlor, a library, and a spacious auditorium complete with stage and dressing rooms.

A credit to the Sisters of St. Joseph and the city of London, St. Mary's Hospital has yet another distinction. This hospital was constructed on its original estimate of $1,300,000 which was made about two years before it was completed. Construction was financed through government grants, a diocesan campaign, and private donations.

Second Floor

Legend

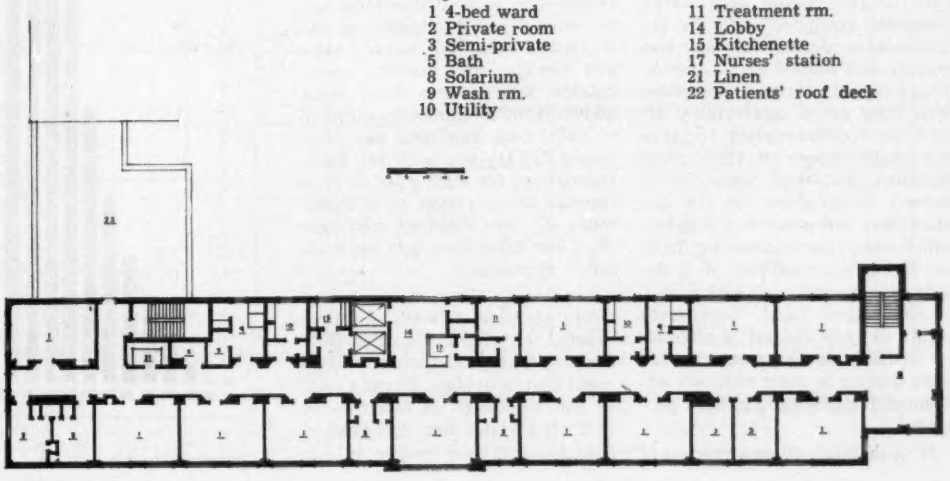
1 4-bed ward
2 Private rm.
3 Semi-private
5 Bath
8 Solarium
9 Wash rm.
10 Utility
11 Treatment rm.
14 Lobby
15 Kitchenette
17 Nurses' station
19 Dining room
20 Servery
21 Linen



Third Floor

Legend

1 4-bed ward
2 Private room
3 Semi-private
5 Bath
8 Solarium
9 Wash rm.
10 Utility
11 Treatment rm.
14 Lobby
15 Kitchenette
17 Nurses' station
21 Linen
22 Patients' roof deck



A Decade in Retrospect

D. W. Ogilvie,
Director,
Ontario Blue Cross Plan,
Toronto, Ont.

WHEN studying the hospitalization experience and comparative figures of one Blue Cross Plan in its first decade of service, it would seem logical —and fair— to consider briefly conditions which existed at the time the Ontario Plan was launched.

The public hospitals of Ontario were experiencing much the same conditions of public hospitals elsewhere on the continent, prior to March 17, 1941, when the Ontario Hospital Association opened the doors of the Plan for Hospital Care to the people of Ontario. Hospitals, equipped with the facilities as modern as the day had to offer, and staffed with as many, if not more, trained personnel than they could comfortably afford, were endeavouring to serve the health needs of their communities. But they were handicapped on all sides. On the one hand they were serving a public which was just recovering from the devastating effects of a decade of economic depression and, on the other hand, they were trying to keep abreast of scientific medical developments which were adding to their need for additional facilities and skilled personnel.

It is difficult to imagine what the hospital situation would be in Ontario today if the hospitals themselves, with the leadership of their Association in Ontario, had not taken positive action. A great deal of credit is due to the personal initiative and hard work of three of the Association's Board members, Dr. G. Harvey Agnew and A. J. Swanson of Toronto, and R. Fraser Armstrong of Kingston, Ontario, who "talked up" the idea of a hospital plan for Ontario. The early discussions of this farsighted trio led to the development of the Ontario Plan by the Association modelled after the hospital "prepayment" plans which had begun to spring up in the United States and already had had a Canadian debut in the Province of Manitoba. However, Blue Cross in Ontario, like other Blue Cross Plans, has had to measure up and adjust itself to the exigencies and variations of the times. The almost complete reversal of economic conditions during the ten-year period are eloquently interpreted in the current quip:

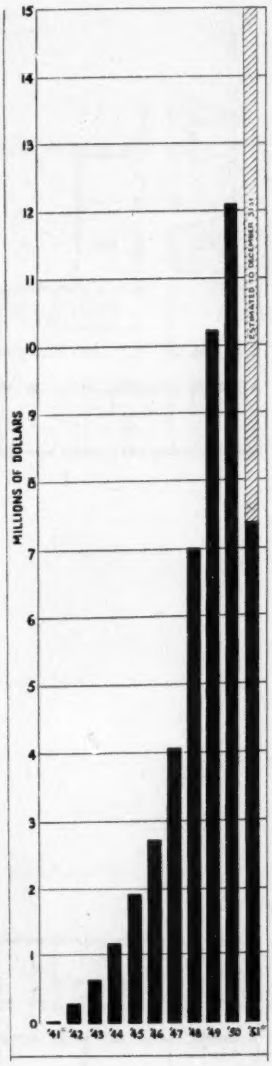
"In 1941 we were broke for a week
so we ate hamburg—
In 1951 we ate hamburg for a week
—so we were broke!"

Hospitalization Benefits

When the Plan was launched on March 17, 1941, it offered to the public a contract limited to the immediate needs of the public for hospitalization protection. The maximum number of days' care available under the Plan was twenty-one, and extra services did not include such benefits as intravenous solutions, x-ray, oxygen therapy, and modern medications which have since been added. Now the minimum number of days' care available has been raised to fifty-one with ten additional days for each year of continuous participation to a maximum of two hundred and one days for subscriber and each eligible dependant.

Looking at Chart A, "Value of Hospitalization Benefits Provided", the effectiveness of Blue Cross as a hospital-sponsored payment Plan is evident. From a total of about $300,000 in benefits for 1942 (the Plan's first full year of operation) to over twelve million dollars in 1950, and an estimated fifteen million dollars for 1951, there has been a steady climb in the amount of hospitalization prepaid each year. It is estimated that 1951 payments to hospitals will represent about 30 per cent of pay-patient income received by the Plan's member hospitals in Ontario. In 1942, payments represent-

Chart "A"
Value of Benefits Provided
Decade Ending June 30, 1951



*Six months only

ed 2.34 per cent of pay-patient income.

Chart B, "Percentage Variance of Hospitalization Expense Factors", requires a little more study than the straightforward information in Chart A.

The broken line shows the percentage increase in the incidence of admission — the number of Plan participants per thousand admitted to hospital annually. It is difficult to explain the immediate drop in this curve to the end of the first half of 1942 except to assume that this was caused by the small enrolment of the Plan which was not yet sufficient to establish a balanced, clear-cut pattern of operation. Nevertheless, as soon as the Plan became firmly established, incidence fell into line more accurately. Until the middle of 1947, the number of people admitted to hospital created no problem but from that time until the middle of 1950 the upward trend was very sharp, showing an increase of 27 per cent. From the middle of 1950 to the end of June 1951 there was another 2 per cent rise. It appears, for the time being at least, that incidence is showing some promise of becoming more stable.

The current tendency of incidence to "level off" may be attributed to two factors— first, the discontinuance of additional enrolment to loosely-held-together groups which had no sound actuarial basis (this embraces such organizations as women's or men's social organizations, church groups, clubs, associations, et cetera); secondly, the Plan has adopted stricter underwriting practices, particularly with regard to group enrolment procedures, required minimum percentage for new groups, and the maintaining of a suitable minimum percentage for enrolled groups.

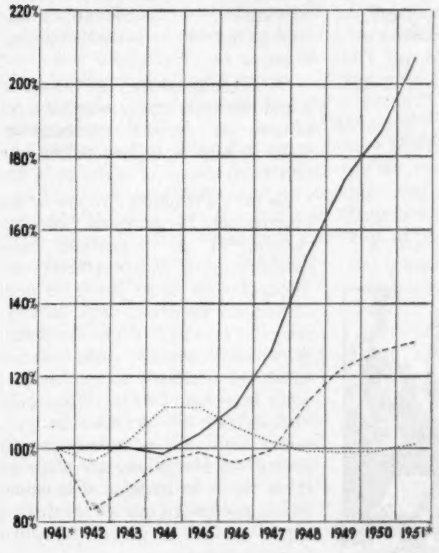
The second line on the chart (dotted) indicates the trend of length-of-stay per admission. This factor reached a peak in the period from June, 1944 to July, 1945 after which time there was a steady decline to the middle of 1948 when the present almost constant average was reached. The decline in length of stay presumably has its foundation in the practice of early ambulation, earlier admission made possible by the fact that prepaid care poses no financial problem, and the shortage of hospital facilities which necessitates the discharge of patients who have improved sufficiently to be cared for at home.

It is probably significant that the length of stay has shortened and held as the incidence of ad-

(Concluded on page 86)

Chart "B"

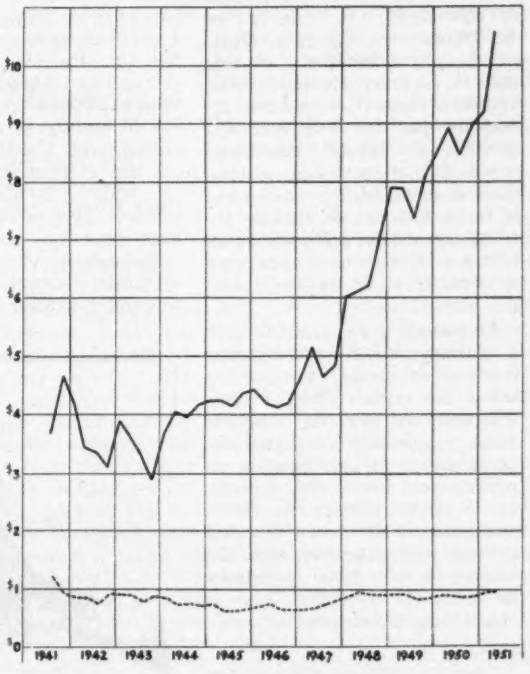
Percentage Variance of Hospitalization Expense Factors Decade Ending June 30, 1951



Cost per day
Length of stay
Incidence
*Averages for years 1941 and 1951 are for six months only

Chart "C"

Comparative Increase in Hospitalization and Administrative Expense per Participant Decade Ending June 30, 1951



Hospitalization Expense
Administrative Expense

Admission et Départ du Patient

Soeur Noémi de Montfort, F.D.L.S., I.E.

Assistant-administratice, Hôpital Sainte-Justine, Montréal, Québec.

ON NE saurait établir une routine d'admission, car un problème individuel se pose à la réception de chaque malade; de ce malade sujet à des réactions psychiques, émotionnelles et quelquefois morales, en plus de la maladie qui lui ouvre la porte de l'hôpital.

L'hôpital admet le malade "le membre souffrant du Christ", que celuici soit riche ou pauvre, catholique ou protestant, voir même païen, citoyen ou étranger, blanc ou noir, homme, femme ou enfant. Par le prestige que lui confère la souffrance dont il est la victime, ce malade commande en maître à des hommes d'université, faisant appel à leur science médicale; à des infirmières, dignes collaboratrices des médecins, qui, pleines de dévouement et de prévenances délicates, le soigneront avec sollicitude; à la science respective de toute une équipe de techniciens et de techniciennes des laboratoires, rayons-x, diététique, physiothérapie, services sociaux. La merveille quotidienne de bonne tenue d'une maison, accomplie par les employés des services de cuisine, buanderie, chaufferie et entretien général dans le grand édifice qui devient le foyer nouveau du malade entrant aujourd'hui à l'hôpital, contribue à lui assurer le maximum de sécurité et de confiance dont il a besoin.

Le malade qui commande ainsi à l'armée d'élite de l'hôpital modern se confie, s'abandonne entre ses mains dans l'espoir d'obtenir une guérison complète aussi rapidement que possible; ou du moins, une amélioration qui parfois peut seule être espérée; et, si la Providence en décide autrement, il en vient à accepter la mort, généreusement, muni des secours de la religion et entouré de toute le réconfort que la charité chrétienne peut apporter.

Présenté à l'Ecole d'Administration Hospitalière, Comité des Hôpitaux du Québec, Montréal, 1950.

Le bureau d'admission doit être situé non loin de l'entrée principale et cependant dans une partie assez tranquille, retirée du corridor central; non exposé aux odeurs de la cuisine ou autres émanations dites d'hôpital. Ce local doit être accessible aux médecins, et attenant, si possible, à la comptabilité. Que l'hôpital soit grand ou petit, la pièce est toujours isolée afin que l'interview puisse se faire privément.

Une atmosphère professionnelle, l'esprit humanitaire, et tout de charité qui doit régner dans ce service, contribuent à faire disparaître l'anxiété du patient et les préjugés des parents à qui il répugne souvent de confier un être cher à des mains étrangères. L'aspect physique du local exerce une grande influence sur le malade et ceux qui l'accompagnent. L'ordre, la propreté, un bon éclairage, le Crucifix à la place d'honneur, quelques tentures appropriées, stores vénitiens peut-être, quelques decorations sobres et de bon goût atténuent l'aspect austère qu'on s'attend à trouver dans un hôpital. Le bureau est accueillant; deux fauteuils attendent le malade et celui qui l'accompagne; un plus grand nombre est inutile car on ne recommande qu'un seul témoin à l'interview.



L'hospitalité, de mise à tous les étages d'un hôpital, sera exercée largement au service d'admission. Le malade nous crée souvent un embarras en nous demandant un verre d'eau; quelques chambres de repos à proximité de ce bureau tant pour hommes que pour femmes sont donc nécessaires; chambres confortables, pourvues d'accessoires d'hygiène indispensables. L'hôpital fournit des serviettes et gobelets en papier, du savon, et caetera, et ces endroits publics sont l'objet d'une surveillance constante au point de vue propreté. Un téléphone public est à la disposition des parents et des visiteurs. Terminons en mentionnant une première prévenance qui convenient dans un hôpital catholique, à savoir, la possibilité, si nécessaire, de faire administrer le sacrement d'Extrême-Oncton à la salle d'urgence.

On recommande le présence d'une réceptionniste, religieuse ou laïque, au service d'admission. Voici quelques scènes prises sur le vif.

La port d'urgence s'ouvre et un vicaire de la paroisse voisine, remplaçant de Monsieur l'aumônier, dit à la réceptionniste: "Voulez-vous faire sortir le personnel, ce mourant veut se confesser". Il s'agit d'un accidenté gravement atteint mais encore conscient. Autour de la civière, deux internes et deux infirmières sont entrain de terminer les premiers soins sans se préoccuper du prêtre. La réceptionniste offre de faire tenir le masque d'oxygène par le prêtre, ce qui a l'effet d'un signal et tout le monde se retire immédiatement.

L'infirmière fait sortir de la salle d'urgence, par deux fois,

(Suite en page 90)

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The Canadian Dietetic
Association

Newer Aspects of Diet Therapy

C. Keith Stuart, M.D., F.A.C.P.,
Department of Medicine,
McGregor Clinic, Hamilton, Ont.

IT MAY be as the man says that nothing is new. However, the making of the common staple of all our diets, bread, is an Egyptian discovery only six thousand years old. In Roman times, baking became a highly skilled craft and the bakers formed themselves into guilds with rights guaranteed by the state. Thus, in case you need to be reminded, dietitians are members of a highly regarded craft organized and recognized as such at least from Roman times.

Within our lifetime, the planning of an adequate diet has progressed from the place where one needed to have just so many calories per day to the point where we realize that balance is the essence of proper diet. This balance has to include, not only the correct portions of protein, carbohydrate, and fat, but must take cognizance of the mineral and vitamin content. Still deeper in this problem of balance comes the importance of the type of protein, of carbohydrate, of fat, and the relative proportions of minerals and vitamins in various foods.

The relation of proper diet to the rise and fall of the vigour of an individual and/or of a nation is a problem of great interest to us all. The possibility, and even the probability, that the state of our soil and our diet habits bears a direct relation to individual health as well as national health and strength is becoming increasingly apparent.

Analysis of vegetables grown in different locales has revealed as much as 1000 per cent difference in the quantity of mineral present in a carrot. This mineral deficiency or discrepancy must also affect the value of the anmial protein we eat. Even as short a time as fifty years ago, nutritional anaemia in hogs fed on home-grown grains was rare. Today, baby pigs are fed extra iron from infancy. Several years ago a research team in a sheep-raising country, investigating a paralysing disease of sheep, felt that the disease was caused by a deficiency of a trace mineral. Over half of that research team finally developed signs of multiple sclerosis. Perhaps this was just "happenstance", but in any event an example such as this forces us again and again to examine the supreme importance of food.

Refinement of techniques in the analytical chemical field has helped us to evaluate the importance of the more abundant minerals in the body. The first of these has been sodium, but potassium is rapidly being investigated. It may be said that we have been living in the sodium era but are rapidly approaching the era of potassium. We all know that in certain disease states, such as heart failure and nephritis, the body holds sodium. The sodium under these circumstances is retained in the interstitial spaces. In order to keep it isotonic, water is therefore also retained in those spaces. The first fifteen pounds of extra retained water may fail to show any signs of oedema. However, in spite of the extra water, the body tissues are actually dehydrated by this salt brine. The patient is frequently very thirsty. This thirst does not mean that water should be restricted but is a distinct indication that the sodium intake should be reduced.

As long as urine is made there is an obligatory salt loss. Ordinarily, the excretion of sodium in twenty-four hours equals the intake. There are two ways to lessen this extra amount of salt in the interstitial spaces. First, dedecrease the amount entering the body and, secondly, increase the elimination of sodium. In order to augment elimination one can use various drugs and medicines, but often dietary measures alone are sufficient. Increase the urine by giving more water and this in turn will increase the obligatory sodium loss. This is important, but, of equal importance is the pH of the diet. The loss is enhanced by feeding a diet high in acid ash.

A diet low in sodium is relatively simple to plan and to be effective should contain 2 gms. or less. However, the diet used for the treatment of oedema should be double-barrelled. It should be not only low in sodium but also high in acid ash. The plan formulated by Schemm and reported in the *Annals of Internal Medicine*, December, 1944, takes both of these factors into consideration. It is still a good guide.

Man is neither a herbivorous nor a carnivorous animal. He is both. His teeth give a hint, in that they are neither the incisors of the rabbit nor the canines of the wolf. They are a combination of both. This is a significant fact. It means that, while man may be able to use many of the cereals for body building and repair, he also needs to eat the flesh of other

An address presented at the Dietetic Section meeting, Ontario Hospital Association convention, Toronto, Oct., 1951.

animals. Scientific evidence of man's carnivorous needs is found in the fact that one, and maybe two, of the amino acids essential for body repair and defence must come from animal sources.

Protein is the most important single factor in our diets. It is the focal point around which our needs are built. Clinically, many evidences of its importance are found. Children need up to 4 gms. per kilogram of body weight a day. Adults, in full health, need up to 1 gm. per kilogram of body weight a day. Frequently anaemia is traced to lack of adequate protein. It is impossible to build haemoglobin without globulin because the word itself denotes a combination of the two. Intakes of as much as 200 gms. a day of protein may be needed to correct a severe anaemia.

The globulin fraction is the source of the immune bodies that fight infection. This reminds us that meat is necessary to keep well and also to get well. Therefore, someone convalescing from illness should receive a high protein diet. This is also very true in the case of burns and, to a lesser extent, fractures. In general, healing is enhanced in the presence of plenty of first-grade protein.

Starvation gives evidence of a crying need for protein. It can be seen in the spindly arms and legs of the emaciated person who has destroyed his own muscle in his body's struggle to survive. In the overweight person this loss may be masked by overlying fat pads. In either case, anaemia, poor resistance to infection and even the swollen ankles of starvation oedema, may give evidence of essential protein starvation. Older people, whose teeth are poor and whose appetite is fickle, are frequently found to be protein-starved.

Let me repeat, first-grade proteins are the building blocks of our human edifice. Minerals and vitamins are the mortar and carbohydrates and fat simply the sources of heat and energy.

Fats for Heat and Energy

Fats in the body are extremely active. Until the advent of tagging atoms, fats were thought to be just inert stores of potential energy that one had to carry around in case of need. Now we know they are an everchanging, always available, source of energy. The liver has much to do with fat metabolism. It also appears that the liver can be damaged by excessive fat activity. This is especially true if abundant supplies of protecting protein and sugar are not available. If unprotected, this damage may result in liver disease. In experimental animals it can result in liver cancer. Many of the starved in Europe, during the last great war, developed cirrhosis of the liver after food first became available to them. It is also quite possible that some of the liver disease of South African natives is due to improper balance of diet with too little first-grade protein and too much fat.

Of even greater importance to us overfed residents of North America is the relationship of fats to cardiovascular disease. For years vital statistics have haunted us with the news that heart disease and arteriosclerosis have been our greatest killers. The headlines might blare forth, "Cholesterol, the killer, is at large—all citizens beware!"

Through recent investigation a way of making all animals arteriosclerotic has finally been found. This consists of feeding a diet high in cholesterol and low in phospho-lipids especially lecithin. The same effect can be achieved by ingesting excessive quantities of fats, many of which contain cholesterol, and a normal amount of phospho-lipid. Lecithin acts as a detergent to keep the cholesterol in solution. In order to keep this solution stable, the cholesterol lecithin ratio should be 1:1. When the ratio becomes 2:1 or even 5:1, cholesterol deposits are found in the vessels of the heart, brain, et cetera, and the process of arteriosclerosis has begun. It would seem highly desirable that we prevent such a condition from becoming established in ourselves. This can be done in great part by controlling the amount of fat taken in the diet. Specifically, of course, this is cholesterol but in general it is fat.

Now we know why the insurance company statistics have shown that after thirty years of age man reduces his life expectancy in direct proportion to his percentage of overweight for his age and body build. It would appear in the light of this information that someone should take on the job of changing our dietary habits. Who could that be if not the venerable guild of dietitians, whose business and interest is our diet in health and in disease?

Concerning the actual preparation and composing of a diet, I would not have the gross temerity to speak, but the work of Dragstead may show us something about presenting it to people in general or patients. A few years ago, he was interested in anorexia nervosa, that severe nervous distaste for food that causes metabolic bankruptcy in humans. Using a group of mature guinea pigs, he established the amount of food and calories that maintained constant weight and

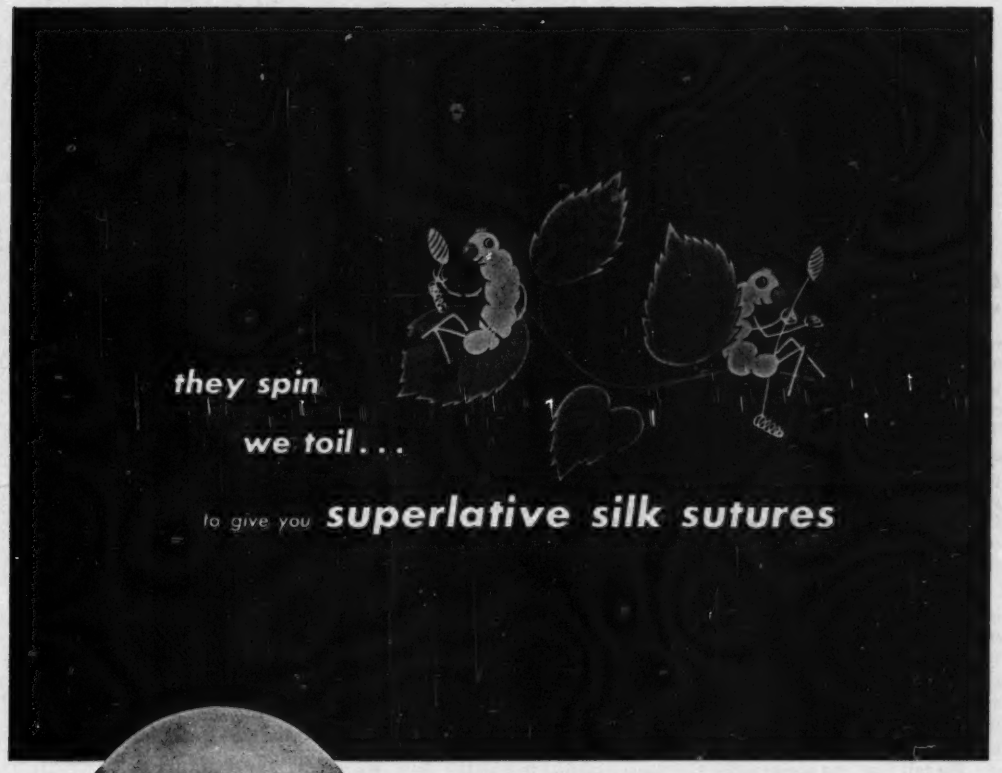
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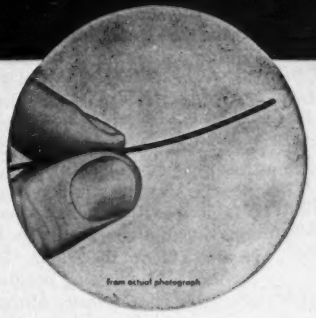
Applications Now Being Received for 1952 C.H.C. Extension Course

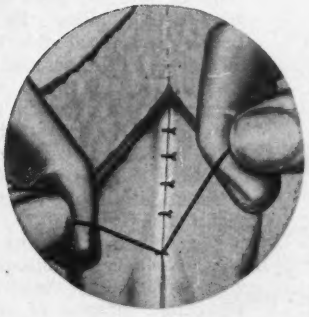
March 31st, 1952, has been set as the date on which applications for the 1952 class of the extension course in hospital organization and management must be submitted. Already many applications have been received and it is suggested that anyone considering enrolment for the class, commencing next September, should not delay in making the necessary arrangements.

All candidates who submit applications prior to January 31st, 1952, will be asked to confirm their applications during March.

Application forms and information concerning the extension course may be obtained from: Secretary, Committee on Education, Canadian Hospital Council, 280 Bloor St. W., Toronto 5, Ont.







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Third Maritime Institute

SOME 93 delegates gathered in Halifax from Nov. 20-24 to attend the third Maritime Institute for Hospital Administrators, Trustees, and Department Heads, which was held in the auditorium of the Victoria General Hospital. This most successful institute was sponsored by the Maritime Hospital Association, working in co-operation with the American College of Hospital Administrators and the Canadian Hospital Council.

In his opening address of welcome, the Hon. Harold Connolly, minister of Health and Welfare for Nova Scotia, suggested that careful scrutiny be made of the recent trends in hospitalization which is becoming an ever increasing burden on the community. He felt that the social security schemes, which have been discussed so much of late, should be viewed with caution as, in his opinion, they are beyond the financial capacity of the community.

With the spotlight focused on the small hospital, Sister Catharine Gerard, adminstrator, Halifax Infirmary, and her program committee, arranged a most interesting and stimulating series of lectures. Neil MacLean, president, Maritime Hospital Association, was chairman of the opening session and Dr. L. O. Bradley, executive secretary, Canadian Hospital Council, brought greetings from the Council.

Ralph H. Gale, superintendent, Saint John General Hospital, Saint John, N.B., described the purpose of the institute as a return to the classroom and briefly sketched the week's lessons. Following Mr. Gale, S. W. Martin, associate executive secretary, Ontario Hospital Association, set up a frame-work for the institute with his description of the "Administrative Functions in a 100-Bed Hospital". He emphasized that if the area of authority, for each job, is developed by careful planning then duplication of responsibilities is avoided. In his speech on "The Administrative Conference", Dr. T. E. Kirk, superintendent, Camp Hill Hospital, Halifax, spoke of the conference as a means of uniting the many hospital departments.

The all important subject "Fire Prevention in Hospitals" received careful consideration by Neil F. MacNeil, fire prevention officer, Camp Hill Hospital. A lively discussion of the topic followed, under the direction of Nova Scotia's provincial fire marshall S. S. Wright, Halifax's fire chief F. C. MacGillivray, and Dr. C. M. Bethume, administrator, Victoria General Hospital, Halifax.

Sister M. Celine, president, Ontario Association of Medical Record Librarians, gave an informative paper on "The Role of the Administrator re Medical Records". Medico-legal aspects were discussed by Sister Celine who also outlined what is being done and can be done to qualify personnel. Many problems which confront the medical record department were aired in the problem clinic which followed.

Basing her paper on the minimum standards for x-ray departments established by the American College of Surgeons, Sister Edmund Campion, president of the Nova Scotia division of the C.S.R.T., gave a comprehensive review of the basic requirements for this department. The type of training most useful for technicians serving smaller hospitals was a question which received considerable emphasis in a discussion from the floor. It was agreed that a training program for a combination x-ray—clinical laboratory technician would fill a real need in these hospitals.

In an address "Blue Cross is your Responsibility", Dr. L. O. Bradley discussed the steadily increasing cost of hospital care in the light of the more complex diagnostic and treatment procedures which are used today. Dr. J. A. MacMillan, chairman of the Maritime Hospital Service Association, also spoke on this subject.

The Thursday morning session was given over to a discussion on civil defence. Rear Admiral F. L. Houghton, director of civil defence for the Halifax area, dealt with the problems which must be

(Concluded on page 102)



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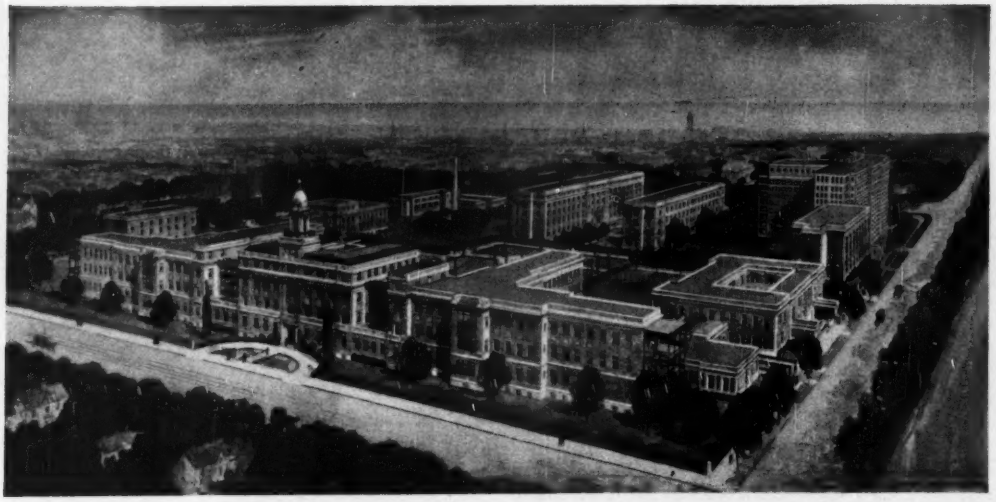
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Aerial view of the present Toronto General Hospital, not including the Wellesley Division.

Toronto General Launches $14,000,000 Campaign

AS a result of a three-year study program the Toronto General Hospital, Toronto, Ont., has launched an appeal for $14,000,000 this month to modernize and expand the hospital. This is one of the largest sums ever sought from the public at large for a Canadian hospital.

Improvements planned for the hospital include seven new buildings to provide more public beds, additional and centralized operating rooms, new emergency and admitting departments, increased accommodation for nurses and interns, more space for rehabilitation of physically-impaired patients, and modernization of existing out-moded public wards and service facilities. The project will add 400 new beds, increasing the bed capacity in the Toronto General Hospital to more than 1,700.

The expansion program to be undertaken and the approximate cost of the various units is as follows:

1. Construction of a four-storey building to house all surgical operating rooms, two ward floors for patients in certain specialized services, new lecture rooms, and quarters for the interns—$4,035,000.

2. Modernization of the outmoded public wards to meet the needs of modern medical practice, improvement and re-equipping the kitchen which prepares most of the 2,000,000 hospital meals each year, and improvements in the surgical supply and laboratories—$1,840,000.

3. Construction of a four-storey emergency and admitting building, including 75 beds—$800,000.

4. Construction of a two-storey building to increase the facilities for physiotherapy and occupational therapy work, including a medical gymnasium and a therapeutic pool—$250,000.

5. A new building and modernization of the Wellesley Division of the hospital to include a new nursery, new elevators, air conditioning, and fire-proofing—$1,000,000.

6. Modernization of the hospital laundry building for washing and ironing the daily load of 15,000 pounds of sheets, towels, and other articles—$300,000.

7. Construction of a new nurses residence to accommodate about 200 additional nurses—$1,500,000.

8. Construction of an obstetrics and gynæcology building with 250 beds to meet the increasing needs for care in these two services—$1,650,000.

9. Construction of a new building to contain a complete eye service, including 75 beds—$1,350,000.

10. Equipment required in new building and modernization projects—$1,275,000.



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◂ Notes About People ▸

Dr. F. B. Roth Appointed Sask. Deputy Minister of Health

Dr. F. B. Roth of Regina, formerly director of the hospital administration and standards division of the Saskatchewan Department of Public Health and, in recent months, also director of the new University of Saskatchewan Hospital, Saskatoon, has been appointed deputy minister of health for Saskatchewan. Dr. Roth Succeeds Dr. F. D. Mott, who resigned as of the end of last month.

In 1936, Dr. Roth graduated in medicine from the University of Western Ontario, London, and, spent several years in general practice in Atlin, B.C. and Whitehorse, Yukon. He enrolled in the post-graduate course in hospital administration at the University of Toronto, in 1948, and served his administrative residency at the Winnipeg General Hospital, Winnipeg. In 1950 Dr. Roth joined the Saskatchewan Health Services Planning Commission and became director of the hospital administration and standards division of the health department. Last year he was also appointed to membership in the S.H.S.P.C.

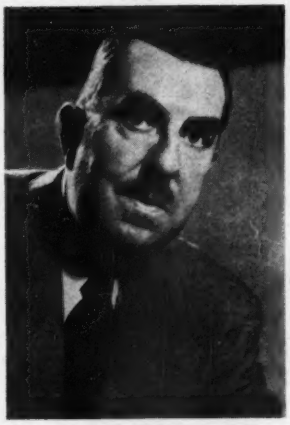


Dr. F. B. Roth

Dr. G. W. Peacock Appointed to Saskatchewan Government Post

The appointment of Dr. George W. Peacock as director of hospital administration and standards in the Saskatchewan department of public health was announced recently by the public service commission. Dr. Peacock succeeds Dr. F. B. Roth, newly appointed deputy minister of health for Saskatchewan.

After obtaining his medical degree from the University of Toronto in 1932, Dr. Peacock was engaged in private practice at



Dr. G. W. Peacock

Grafton, Ont., for several years. Later, he took the post-graduate course in hospital administration at the University of Toronto. For the past three and a half years, he served as assistant superintendent (medical) of the Kingston General Hospital, Kingston, Ont. Dr. Peacock took over his new position in December.

* * * *

Administrator Appointed for New Hospital at Burnaby, B.C.

Harry Baxendale, administrator of the King's Daughters' Hospital, Duncan, B.C., for the past five years, has been appointed administrator of the new hospital at Burnaby, B.C., which is scheduled for completion in May. Prior to his appointment at Duncan, Mr. Baxendale served with the Columbia Coast Mission from 1940 to 1946 and was in charge of hospitals at Alert Bay, Pender Harbour, and Rocky Bay, British Columbia. Mr. Baxendale assumed his new duties in December.

* * * *

Director of Nursing Appointed for Hospital at Fort William, Ont.

Sylvia Davidson, Reg. N., has assumed her new duties as director of nursing at McKellar General Hospital, Fort William, Ont. Miss Davidson is a graduate of the hospital and served there as night supervisor of nurses from 1947 to 49. During World War II, she was a nursing sister with the Royal Canadian Air Force. In 1949, Miss Davidson accepted the post of matron administrator at the Creston Valley Hospital, Creston, B.C. and held that position until her recent appointment.

* * * *

Allan Corner New Administrator of Nanaimo General Hospital, B.C.

Allan S. L. Corner, newly appointed administrator of Nanaimo General Hospital, Nanaimo, B.C.,

(Concluded on page 96)



Allan S. L. Corner



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Canadian Society of Laboratory Technologists,
Hamilton, Ont.

THE HOSPITAL, as part of the expanding health program, is at long last reaping the reward for its patients. All departments in the hospital reflect this expansion and none more so than the department of pathology. There the great impetus in scientific research provided by the continuing discovery of new techniques and equipment has created a new and rapidly developing field of endeavour in the medical diagnostic services. Laboratory technology is as old as Methuselah in the history of medicine, but it is as young as any babe in the story of the modern hospital. Like any lusty infant, it is growing apace and will continue to do so as the diagnostic units which it serves continue to develop as they are doing at present. The natural result of this growth is an ever increasing demand for adequately trained technologists to fill the laboratories and to provide the doctors and, subsequently, the patients with the accurate and dependable service which they have a right to expect.

The Canadian Society of Laboratory Technologists maintains a registry for technicians under agreement with the Canadian Medical Association. The present rules and regulations pertaining to registration and other general information follow.

Rules and Regulations

Education

The minimum age for applicants is 18 years.

1. Senior Matriculation or the equivalent educational standing in the various provinces.

2. Two science subjects are required, one of which must be chemistry.

3. After July 1st, 1952, two of either algebra, geometry or trigonometry will also be required in addition to chemistry and the second science.

4. An official transcript of educational credits *must* be submitted with application form.

On this page are the provincial academic standings required. (In any case where the number of compulsory subjects does not equal that or the number of subjects required, optional subjects may be taken to meet the requirements.)

Student Registration

In order to avoid unnecessary delays and disappointments in approving final application, students are requested to register with the Society for student membership at the *commencement* of their course of training.

Fee is $2.00 per year for which student receives *Canadian Journal of Medical Technology*, the official publication of the Society, other periodicals, and general information.

Examination and Registration

Fee of $25.00 must accompany application for registration. This fee includes the cost of examination and the first year's annual membership. *Note:* If remitting by cheque please include the necessary exchange.

Depositing of cheque or money order does not necessarily mean approval of application for membership.

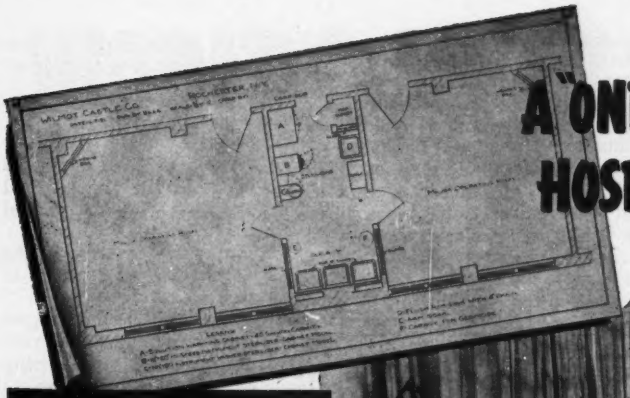
Fee of $25.00 will be refunded if application is not approved for examination.

Sum of $5.00 will be refunded if applicant fails to pass the examin-

Province	Standing	No. of Senior Matric. Subjects Required
British Columbia	Grade XIII Senior Matric	5
Alberta	Grade XII Senior Matric	7
Saskatchewan	Grade XII Senior Matric	8
Manitoba	Grade XII Senior Matric	5
Ontario	Grade XIII Hon. Grad.	8
Quebec	Senior High School Leaving	4
	Senior Matric of McGill University	5
	Cert. Lettres-Sciences* University of Montreal	
	Senior Matric of Basile-Moreau College	
New Brunswick	Grade XIII Senior Matric	6
Nova Scotia	Grade XII Senior Leaving	5
P. E. I.	3rd Year Prince of Wales College	5
Newfoundland	1st Year of Memorial University College	5

**All other certificates of Lettres-Sciences, must be evaluated by Secretary of Public Instruction for Province of Quebec before they can be accepted as equivalent to the required standing.*

NOTE: *In all provinces, Senior Matric subjects must include chemistry, one of physics or biology and two of either algibra, geometry, or trigonometry.*



A "ONE-JUMP-AHEAD HOSPITAL"* THEY CALL IT

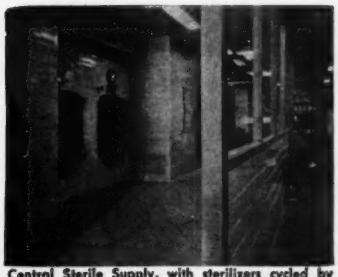
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Canada's newly completed KITCHENER-WATERLOO 347 bed hospital, widely publicized as the last word in modern construction, facilities and appointments, selected Castle Sterilizers and Surgical Lights for further acknowledgment of Castle's established leadership.





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Central Sterile Supply, with sterilizers cycled by Thermatic governors with remote control supervision.

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- *Only 3 sterilizing units required!*—Castle Hi-Speed Emergency Sterilizer . . . Castle Pressure Instrument Washer-Sterilizer . . . Castle Solution and Blanket Warmer. All dressings, utensils and flasked solutions and distilled water supplied by Central Sterile Supply.
- ARCHITECTS: Govan, Ferguson, Lindsay, Kaminker, Maw, Langley, Keenleyside—Toronto.

*The Canadian Hospital, Vol. 28, No. 7, p. 79, July, 1951.

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ation and does not wish to rewrite.

In case of failure, applicant may try the examination again within a year for an additional sum of $5.00.

Photograph (not larger than 3" x 3") must be attached to application form, together with the above fee of $25.00.

Application must be returned for the spring examination not later that March 1st for registered students, and February 1st for applicants who have not been registered as students. Application must be returned for the Fall examination not later than September 1st for registered students, and August 1st for applicants who have not been registered as students.

In case of failure, official notification to rewrite the examination must be given by the applicant not later than the above dates for the next examination.

Applications received after the above dates cannot be considered until the next examination.

Copies of past examination questions are available for 25 cents.

The *Syllabus of Studies* can be purchased for 50 cents.

General Certificate

Applicant must have had at least 12 months' training in an *approved* hospital training centre in the following: bacteriology, biochemistry, histology, parasitology, serology, and haematology.

Specialist Certificate

Applicant must hold a General Certificate and, in addition, have had at least two years' experience in the special field; or applicant must have senior matriculation with the necessary prerequisites as outlined above and, in addition, have had at least five years' experience in the special field; or applicant must be a university graduate in biological sciences (accredited university) and, *in addition*, have had at least two years' experience in the special field (exclusive of undergraduate studies). Fee of $25.00 must accompany application for specialist examination. Only one specialist examination may be taken in any one year.

Examinations

Examinations are held twice yearly. Unless unforeseen circumstances occur these examinations will be held as follows: spring examination—latter part of April or first part of May; fall examination —latter part of October or first part of November. Notices regarding the exact time and place of writing will be sent to the candidate approximately two weeks previous to the examination.

General Examination (duration 1½ days)

(a) Consists of two parts: 1. Oral and practical; 2. Written papers consisting of five subsections in the following: bacteriology, haematology, serology, biochemistry (including general knowledge), and histology.

(b) Pass mark—50 per cent on each subsection, 60 per cent of total.

(c) Supplementary examinations: Candidates must repeat the whole paper if they fail in more than one subsection or if they fail to obtain 60 per cent on the total as a final percentage, although passing each subsection. If the candidate fails in not more than one subsection, a supplementary examination may be taken in the subsection in which failure occurred. Pass mark is 60 per cent.

Specialist examination (duration 1 day)

(a) consists of three parts: oral and practical; written; thesis of at least 1,000 words based upon one or more of the following groups *or* any other subject matter approved by the examination committee. These groups are: review of the literature on some specific phase; original work carried out by the technologist; write up of some special case with particular emphasis on the laboratory work; a theory advanced by the technologist.

(b) Pass mark—60 per cent on each three parts, 75 per cent on the total.

(c) Supplementary examinations: candidates must repeat the whole examination if they fail in more than one part. If the candidate fails in only one part of the examination, a supplementary examination may be taken in the part in which failure occurred.

(d) The thesis must be submitted along with the candidate's application.

Annual Renewal of Membership

1. Renewal of membership for each individual year must be made by returning the renewal form, together with the annual membership fee of $12.00.

2. Membership fee is due and payable the first of January of each year.

3. Membership cards will be issued to the member when the renewal form and the membership fee have been received. Please cooperate in the completion of these forms.

4. Associate membership (fee—$3.00) is open to those members who have ceased to be actively engaged in laboratory practice by reason of illness, change in marital status, or for any other cause acceptable to the executive committee.

5. By-law number 5 reads: "Any member being four (4) months in arrears in payment of dues or assessments may be suspended by the executive. Such members may, upon payment of arrears and assessment be reinstated by the executive."

Annual dues to be paid before May 1st.

Approved Schools

The Canadian Medical Association Committee on Approval of Training Schools has approved the following laboratories for the training of medical technologists. For details of the individual courses of instruction, please contact the individual laboratory directors, who are listed below.

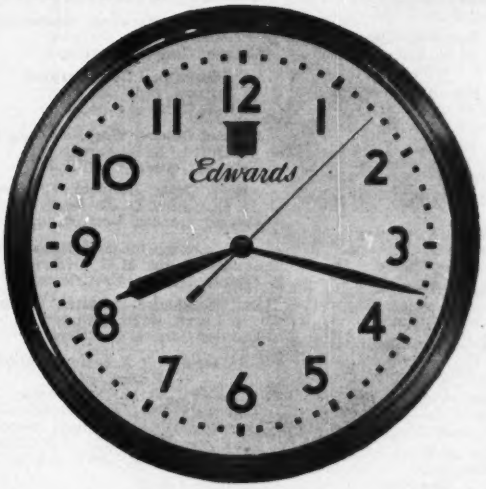
Pathological Institute, Halifax, N.S.
D. J. MacKenzie, M.D., Director of Laboratory.
Courses: 1. General Certificate, 2. Specialties: bacteriology, haemattology, pathological chemistry and histology. (Instruction at Provincial Laboratory on work for V.G.H. and a group of Halifax and Provincial hospitals).

Halifax Infirmary
V. N. MacKay, M.D., Director.
Course: General Certificate.

St. Martha's Hospital, Antigonish, N.S.
O. C. MacIntosh, M.D., Director.
Course: General Certificate.

Provincial Sanatorium and Provincial Laboratories, Charlottetown, P.E.I.
J. H. Shaw, M.D., Director.
Course: General Certificate.

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SIMPLE AUTOMATIC RESET is a major feature of Edwards system. When power is interrupted, batteries keep selected clocks running at correct time. When power returns, *dual* motors operate remaining clocks at accelerated rate until restored to correct time.

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Saint John General Hospital, Saint John, N.B.
R. A. H. MacKeen, M.D., Director.
Course: General Certificate.

Lancaster D.V.A. Hospital, Saint John, N.B.
Arnold Branch, M.D., Director.
Course: General Certificate.

Hotel Dieu de Quebec, Quebec, P.Q.
Le Professeur Henri Marcoux, M. D., Director.
Course: 1. General Certificate, 2. Specialties: histology, haematology, bacteriology, pathological chemistry.

Hôpital St. Francois d'Assise, Quebec, P.Q.
Hector Turcotte, M.D., Director.
Course: General Certificate.

Hôpital du Saint-Sacrement, Quebec, P.Q.
J. Edouard Morin, M.D., F.R.S. (C)., F.R.C.P. (Can)., Director.
Course: General Certificate.

Hotel Dieu de Montreal
Gaston Gosselin, M.D., F. C. I. C., Director.
Course: General Certificate.

Hôpital Saint-Luc, Montreal
Paul Martin, M.D., Director.
Course: Specialist: bacteriology, serology.

Hotel-Dieu St. Vallier, Chicoutimi, P.Q.
Wilfrid Lachance, M.D., Director.
Course: General Certificate.

Hôpital Sainte-Justine, Montreal
N. R. Bouziane, M.D., Director.
Course: General Certificate.

Jewish General Hospital, Montreal
M. A. Simon, M.D., Director.
Course: General Certificate.

Hôpital Notre Dame, Montreal
Albert Bertrand, M.D., Director.
Course: General Certificate.

Children's Memorial Hospital, Montreal
F. W. Wiglesworth, M.D., Director.
Course: General Certificate.

Hôpital du Sacre Coeur Cartierville, P.Q.
J. Georges Manseau, M.D., Director.
Course: General Certificate.

St. Jean De Dieu Hospital Gamelin, P.Q.
P. E. Laurin, M.D., Director.
Course: General Certificate.

St. Vincent de Paul General Hospital, Sherbrooke, P.Q.
Jacques Olivier, M.D., Director.
Course: General Certificate.

Ottawa Civic Hospital
Max O. Klotz, M.D., Director.
Courses: 1. General Certificate, 2. Specialties: biochemistry, haematology, histology.

Ottawa General Hospital
D. Magner, M.D., Director.
Courses: 1. General Certificiate, 2. Specialty: haematology.

Kingston General Hospital, Ont.
F. F. Howatt, M.D., Director.
Course: General Certificate.

Hotel Dieu Hospital, Kingston, Ont.
G. F. Kipkie, M.D., Director.
Courses. 1. General Certificate, 2. Specialties: biochemistry, haematology.

Kitchener-Waterloo Hospital Kitchener, Ont.
L. C. Fischer, M.D., Director.
Course: General Certificate.

Belleville General Hospital, Belleville, Ont.
H. H. Lucke, M.D., Director.
Course: General Certificate.

St. Joseph's Hospital, London, Ont.
F. W. Luney, M.D., Director.
Course: General Certificate.

Victoria Hospital, London, Ont.
E. M. Watson, M.D., Director.
Course: General Certificate.

Sunnybrook Hospital, Toronto
J. A. Blanchard, M.D., Director.
Course: General Certificate.

St. Joseph's Hospital, Toronto
L. S. Mautner, M.D., Director.
Course: General Certificate.

St. Michael's Hospital, Toronto
William Magner, M.D., Director.
Courses: 1. General Certificate, 2. Specialties: bacteriology, histology, biochemistry.

Toronto Western Hospital
Chester McLean, M.D., Director.
Course: General Certificate.

Toronto General Hospital
William Robinson, M.B., Director.
Course: General Certificate.

Toronto East General Hospital
S. F. Penny, M.D., Director.
Course: General Certificate.

Women's College Hospital, Toronto
E. M. Macdonald, M.D., Director.
Course: General Certificate.

Wellesley Division of Toronto General Hospital
Harold Gold, M.D., Director.
Course: General Certificate.

Hamilton General Hospital, Ont.
William J. Deadman, M.D., Director.
Course: General Certificate.

Mountain Sanitorium, Hamilton
A. R. Armstrong, M.D., Director.
Courses: 1. General Certificate, 2. Specialty: bacteriology.

St. Joseph's Hospital, Hamilton
E. N. Ballantyne, M.D., Director.
Course: General Certificate.

St. Catharines General Hospital, St. Catharines, Ont.
Lorne Whitaker, M.D., Director.
Course: General Certificate.

Stratford General Hospital, Stratford, Ont.
J. L. Penistan, M.D., Director.
Course: General Certificate.

Grace Hospital, Windsor, Ont.
S. M. Asselstine, M.D., Director.
Course: General Certificate.

Winnipeg General Hospital
Daniel Nicholson, M.D., Director.
Course: General Certificate.

Deer Lodge Hospital, Winnipeg
T. H. Williams, M.D., Director.
Course: General Certificate.

Misericordia General Hospital, Winnipeg
O. C. Trainer, M.D., Director.
Course: General Certificate.

St. Boniface Hospital, St. Boniface, Man.
James Prendergast, M.D., Director.
Course: General Certificate.

Regina General Hospital
J. D. Stephen, M.D., Director.
Courses: 1. General Certificate, 2. Specialties: histology, haematology, bacteriology.

Regina Grey Nuns' Hospital
Stewart Alexander, M.D., Director.
Courses: 1. General Certificate, 2. Specialties: histology, haematology, bacteriology.

Moose Jaw General Hospital—Providence Hospital
Geoffrey Kent, M.Sc., M.D., Director.
Course: General Certificate.

St. Paul's Hospital, Saskatoon
D. F. Moore, M.D., Director.
Course: General Certificate.

Saskatoon City Hospital
J. W. Adams, M.D., Director.
Course: General Certificate.

Colonel Belcher Hospital, Calgary
J. D. Duffin, M.D., Director.
Course: General Certificate.

Holy Cross Hospital, Calgary
J. D. Duffin, M.D., Director.
Course: General Certificate.

Edmonton General Hospital
Samuel Hanson, M.D., Director.
Course: General Certificate.

Royal Alexandra Hospital, Edmonton
W. B. Leach, M.D., Director.
Course: General Certificate.

University of Alberta Hospital, Edmonton
R. Edward Bell, M. D., Director.
Courses: 1. General Certificate, 2. Specialties: bacteriology, haematology, biochemistry, endocrinology and metabolism, pathological histology.

Provincial Mental Hospital Essondale, B.C.
G. A. Nicholson, M.D., Director.
Course: General Certificate.

Vancouver General Hospital
H. K. Fidler, M.D., Director.
Course: General Certificate.

St. Paul's Hospital, Vancouver
H. H. Pitts, M.D., Director.
Course: General Certificate.

Shaughnessy Hospital, Vancouver
J. C. Colbeck, M.D., Director.
Course: General Certificate.

Royal Jubilee Hospital, Victoria
Ross McNeely, M.D., Director.
Course: General Certificate.

St. Joseph's Hospital, Victoria
D. B. Roxburgh, M.D., Director.
Course: General Certificate.

Victoria Veterans' Hospital
George Shanks, M.D., Director.
Course: General Certificate.

The Canadian Society of Laboratory Technologists maintains a placement bureau in order to assist both technicians seeking employment, and hospitals seeking technicians for their laboratories. Within the year it is our hope to be able to publish an annual roster of registered medical laboratory technologists. Such a roster will be made available to hospital personnel throughout Canada. Our head office is situated at 294 Barton Street East, Hamilton, Ontario. Allow us to serve you if we may.



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◂ Health Care Plans ▸

La Croix Bleue du Québec Annonce une Augmentation de Bénéfices

L'Association d'Hospitalisation du Québec offre maintenant à ses groupes trois nouveaux plans comportant une augmentation de protection. C'est ce qu'annonçait récemment monsieur E. Duncan Millican, Directeur général.

Tenant compte d'une tendance très marquée chez les souscripteurs de s'inscrire en nombre toujours grandissant aux plans chirurgical et médical en plus du plan hospitalier, l'Association ré-inscrit présentement ses 6,500 groupes aux nouveaux plans sur une base de protection comportant le plan complet de protection hospitalière, chirurgicale et médicale.

Les nouveaux plans de la Croix Bleue du Québec comportent un plan hospitalier compréhensif, un plan hospitalier à $7.00 par jour, et un plan hospitalier à $6.00 par jour. Sous le plan compréhensif, le coût de la chambre semi-privée est payé en entier. Les services suivants, sous les trois plans sont payés en entier: Usage des salles d'opération et de cystoscopie et de l'équipement de ces salles; substances anesthésiques; analyses de laboratoire, examens courants pathologiques et services biochimiques; épreuves de métabolisme basal; pansements et plâtres; physiothérapie; oxygéno-thérapie et examens d'électro-cardiographie. Les bénéfices de maternité comprennent des allocations de $80.00, $70.00 et $60.00 respectivement. Les souscripteurs ont maintenant droit à 70 jours d'hospitalisation.

Monsieur Millican a de plus indiqué que la Croix Bleue du Québec compte maintenant 625,000 membres sous le plan hospitalier, 525,000 sous le plan chirurgical et 370,000 sous le plan médical. L'Association a payé plus de $26,000,000.00 aux hôpitaux et aux médecins pour soins fournis aux souscripteurs depuis 1942.

Quebec Blue Cross Announces Higher Benefits Under New Plans

Quebec Hospital Service Association is now offering group coverage under three new plans providing higher benefits, E. Duncan Millican, Executive Director, announced recently. Following a trend towards addition of surgical and in-hospital medical care to hospital care coverage which has been growing constantly in the majority of groups, the Association is now converting its 6,500 groups to full hospital-surgical-medical coverage in the new plans.

Quebec Blue Cross now provides comprehensive hospital coverage, $7.00 a day hospital coverage, and $6.00 a day hospital coverage. Under the comprehensive contract, the going rate for semi-private accommodation is paid in full. Under all three plans, the use of operating and cystoscopic rooms and equipment; anaesthetic supplies and materials; laboratory examinations, routine clinical pathology and biochemistry services; basal metabolism tests; dressings and plaster cast materials; physiotherapy; oxygen therapy; and electrocardiogram examinations are paid in full. Maternity benefits comprise allowances of $80.00; $70.00; and $60.00 respectively.

Blue Cross membership figures released recently show that 625,000 Quebec residents are now enrolled for hospital coverage, 525,000 for surgical coverage, and 370,000 for medical coverage. The Association has now paid over $26,000,000.00 to hospitals and doctors on behalf of subscribers since 1942.

Under the new plans, 70-day coverage in hospital is now provided.

* * * *

Large Group Enrolled in Quebec Blue Cross

Hospital, surgical, and medical benefits of the non-profit Blue Cross Plans were made available to 16,500 more Quebec residents in a single group, as the Canadian International Paper Company and its affiliates placed these benefits at the disposal of 6,500 Company employees and their 10,000 dependents. Enrolment took place at the company's head office in Montreal, and in mills, offices and camps in Gatineau, Trois-Rivières, Gaspé, Noranda, Hawkesbury, Maniwaki, and Clova. Protection became effective in September, 1951. Temiscaming was the last location to be enrolled and protection for these employees became effective on January 1st.

Traduction

Les bénéfices hospitaliers, chirurgicaux et médicaux du Plan de la Croix Bleue ont été mis à la disposition de 16,500 résidents du Québec par l'entremise d'un seul groupe, alors que la Canadian International Paper Company et ses filiales a établi ce système pour le bénéfice de son personnel de 6,500 employés ainsi que leurs 10,000 dépendants. L'inscription se fit au Bureau Chef à Montréal, ainsi que dans les moulins, les bureaux et les camps de la Compagne à Gatineau, Trois-Rivières, Gaspé, Noranda, Hawkesbury, Maniwaki et Clova, et le plan est entré en vigueur le ler septembre 1951. Les employés de cette Compagne à Témiscaming ont venu maintenant de se joindre à leurs collègues, et ils participent aussi au Plan de la Croix Bleue à compter du ler janvier 1952.

* * * *

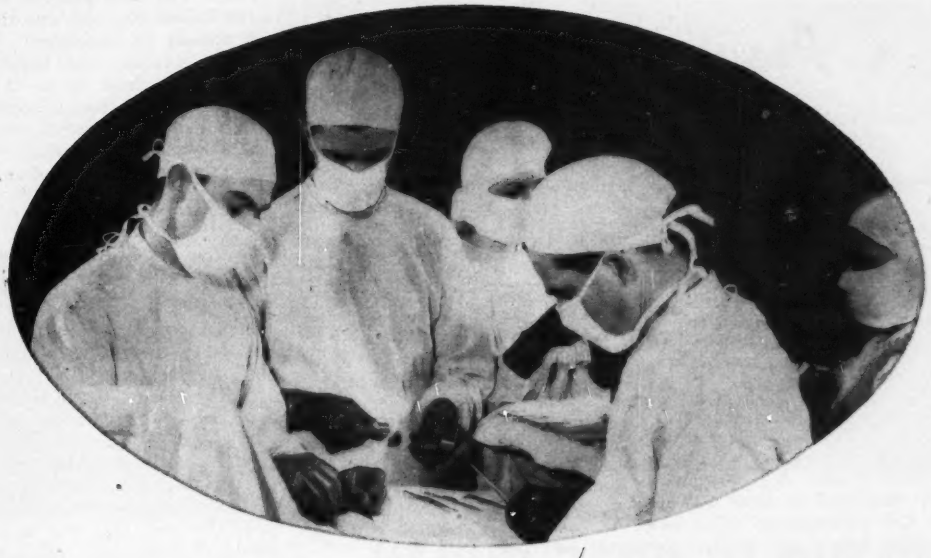
Enrolment Increases

Blue Shield medical care plans have enrolled 21 million people in the United States and Canada, according to a recent announcement by the Blue Shield Commission, Chicago, national association of the non-profit Blue Shield plans, sponsored by the medical profession.

All the animals had left the ark except two snakes lying over in a corner.

"Why don't you go forth and multiply?"

"We can't," answered one, "we're adders."



on the surgical service

Its broad-spectrum antimicrobial activity and ready availability in potent dosage forms suited to institutional use have influenced more and more surgeons to specify

CRYSTALLINE Terramycin HYDROCHLORIDE

Indicated in the prophylaxis and treatment of infections following thoracic, alimentary or urologic surgery; in patients with infectious heart disease, in perforated appendix, and peritonitis; before abdominal section or intestinal anastomosis, and in prolonged labor.

There is a Terramycin dosage form for every hospital service; Medicine, EENT, Obs.-Gyn., OPD, etc.

A hospital pharmacy fully stocked with all Terramycin dosage forms is equipped to meet the diverse needs of every service.

For surgery

CAPSULES: 250 mg., bottles of 16 and 100
100 mg., bottles of 25 and 100
50 mg., bottles of 25 and 100

INTRAVENOUS: 250 mg. in 10 cc. vials
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Also supplied as Elixir, Oral Drops, Ointment, Ophthalmic Ointment, Ophthalmic Solution, Troches, Otic Solution, Soluble Tablets and Nasal.

Pfizer CANADA, LTD. *8311 Royden Road, Mount Royal, Montreal, P. Q.*

Provincial Notes

Nova Scotia

LUNENBURG. A $50,000 campaign, which was launched last summer to aid the new Lunenburg Hospital, exceeded its objective by nearly 20 per cent. The name of the hospital has been changed to the Fishermen's Memorial Hospital.

* * * *

NORTH SYDNEY. A campaign has been launched to raise $250,000 for the construction of a new hospital which will be operated by the Sisters of Charity and will be known as the St. Elizabeth Hospital. Proposed plans call for a six-storey, fire-resistant structure of brick with granite trim. It will contain 184 beds, a 34-bassinet nursery, four operating rooms, an orthopaedic room, cystosopic room, laboratories, and central sterilizing room. The local Rotary Club recently donated $2,000 to the fund.

* * * *

SYDNEY. The new St. Rita's Hospital, which will replace the older 60-bed institution, has been granted $199,000 in federal funds. It will contain 129 beds for active treatment and 42 for the chronically ill.

New Brunswick

MONCTON. The Moncton Hospital has increased its rates by 50 cents per day per bed. Other changes also became effective at the beginning of this month. Operating room fees have been increased from $15 to $20 for major operations and from $9 to $12 for minor operations. The ambulance fee has been raised to $5 and minor changes have been made in the out-patient department charges.

* * * *

SAINT JOHN. A program which involves extensive alterations and the addition of new facilities at St. Joseph's Hospital is now nearing completion. The laboratories have been repainted and redecorated and certain structural changes have been made in various departments. A new medical photographic department has been installed.

Ontario

KINCARDINE. The board of governors of the Kincardine General Hospital will receive $20,000 from the county of Bruce to help defray cost of a new nurses' residence, which is presently under construction. It is expected that the residence will cost approximately $50,000.

* * * *

LONDON. Government approval of a $410,000 provincial subsidy toward the cost of a 410-bed addition to Victoria Hospital has been confirmed by the provincial government. This would be in addition to other provincial aid which has been granted to the hospital.

* * * *

OTTAWA. A new wing will be built at Grace Hospital early this spring. The wing will increase the bed capacity from 56 to 97 and will contain a new nursery and obstetrical department. A campaign for $175,000 to assist in financing the new addition will be launched in May.

PARIS. The new $130,000 wing of the Willett Hospital was officially opened in November. The addition increases the hospital's bed capacity from 36 to 61. In 1922, the Willett Hospital opened with a bed capacity of 15 and, in 1937, the north wing, which contains the operating and x-ray rooms, was constructed.

* * * *

PEMBROKE. Plans for the construction of a new 150-bed Pembroke General Hospital, to replace the present 90-bed structure, were announced recently by the Grey Sisters of the Immaculate Conception, who operate the institution. The five-storey building will be of steel, reinforced concrete, and brick. Work on the $1,626,000 building will commence early this year and will be completed in about a year and a half. The architectural firm of W. L. Somerville, McMurrich, and Oxley, Toronto, are drawing up the plans.

* * * *

SAULT STE. MARIE. Plans for the construction of a new 85-bed wing to the General Hospital have been announced by the Grey Sisters of the Immaculate Conception. It is expected that work on the proposed wing will commence early this year. An isolation unit will be included in the wing, as well as a power house and laundry. Harold J. Smith, Toronto, is the architect.

* * * *

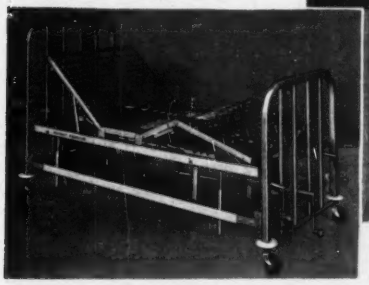
SOUTH PORCUPINE. A house-to-house canvass is being conducted by volunteer workers in an effort to raise $10,000 for the Porcupine General Hospital. This sum will be used to help alleviate the debt which the hospital has accumulated.

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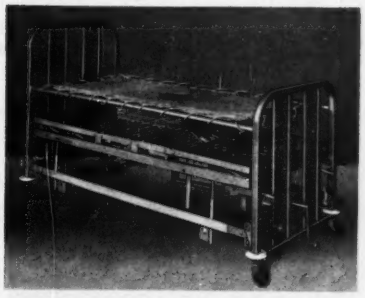
TORONTO. The first sod was turned for a new nurses' residence, at the Wellesley division of the Toronto General Hospital, in November. Designed to accom-



1 **Metal Craft 7000BX Bed** → shown at domestic bed height as preferred by many nervous patients and "up" patients.



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3 The fracture frame can be fitted in place in just 3 minutes.



4 The same bed with scaffolding erected in one of the many positions which may be required.

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modate 250 nurses and to include space for the Institute of Radiotherapy adjacent to the hospital, the building is expected to be completed in about a year and a half. The six-storey brick structure will contain private rooms for each nurse, a teaching unit, nursing arts room, two classrooms, and an auditorium with a seating capacity of 250. To be located west of the old hospital entrance, the building will be constructed so that two wings may be added when required. It will be connected with the main hospital building by a tunnel.

* * * *

TORONTO. A provincial grant of $232,000 has been approved for the new wing of the Toronto East General Hospital. The wing will add 190 beds to the hospital's bed capacity. In addition, the provincial government will pay $158,683 to the hospital to help reduce maintenance costs.

* * * *

TORONTO. An increase of $22.50 a month plus a reduced work week has been granted to some 900 non-professional employees of the Toronto General Hospital and the Wellesley Division. The agreement, which was negotiated between the hospitals and the AFL-TLC Building Service Employees' Union, reduces the work week from 48 to 44 hours. Of the monthly increase $10 is retroactive to January 1st, 1951, an equal amount is dated back to August 1st, 1951, and the remaining $2.50 became effective at the beginning of this month. The agreement expires in December of this year.

* * * *

TORONTO. A charter for a $1,000,000 Lakeshore Hospital has been granted by the Ontario government. The proposed hospital will serve some 112,000 residents in the area between the Humber and Credit rivers, bounded by the Malton area on the north. It will have a capacity of 100 beds and provide minor surgical, obstetrical, medical, and emergency services.

* * * *

UXBRIDGE. Proposed plans for the erection of a new $20,000 hospital are being considered by the town council. The project is to be financed through public subscription, government grants and taxation. A total contribution of $10,000 is expected from the townships of Uxbridge and Scott.

Manitoba

DAUPHIN. The Dauphin General Hospital has purchased a residence which will be converted into a nurses' home. The building, which cost $15,000, will accommodate 16 nurses. It is expected that alterations will cost approximately $10,000. Work will not begin on the building until next summer.

* * * *

MORDEN. Proposed plans for the new Morden Hospital include 35 beds for active treatment cases, a 12-bassinet nursery, and a wing for chronically ill or convalescent patients. In addition, it will contain an out-patient department and space for public health diagnostic services. The hospital has been awarded a federal construction grant of more than $73,300.

* * * *

SELKIRK. The formation of Selkirk General Hospital District No. 31 has been approved by the councillors of St. Andrew's and St. Clement's municipalities and the town of Selkirk. The property of the Selkirk General Hospital was transferred to the new district's board of directors, which assumed control at the beginning of this month. Approval of the formation of the hospital area and the board was also given by the provincial health minister, Hon. Ivan Schultz.

* * * *

VIRDEN. It is expected that the new Virden district hospital will be completed this summer. It will contain 34 beds, a 10-bassinet nursery, two operating rooms, offices for the local health unit, and an x-ray and laboratory diagnostic unit. A federal grant of more than $47,500 has been allotted to the hospital, which will serve about 11,000 people.

Saskatchewan

MELFORT. The Melfort Union Hospital will issue a $30,000 debenture to help finance the new nurses' residence, which is presently under construction. Expected to cost approximately $56,000, the residence will have accommodation for 16 nurses.

* * * *

MOOSE JAW. A superannuation plan in which the hospital matches employees' comtributions dollar-for-dollar has been installed at Providence Hospital. The plan, in which all full-time employees with at least one year's service are eligible to participate, provides for superannuation of female employees at 60 years of age and male employees at 65. Employees contribute five per cent of their salary, with the hospital contributing an equal amount.

Alberta

EDMONTON. Tuberculosis patients from the General, the Royal Alexandra, and the University Hospitals have been moved into the $3,000,000 Aberhart Memorial Hospital, which is located at the south end of the University of Alberta campus. The 300-bed hospital is designed to provide accommodation for tuberculosis patients in all groups: terminal, acute, semi-ambulant and ambulant. The adjoining nurses' home and a smaller building to contain engineering facilities, a laundry, and similar services, will be completed shortly.

Those who bring sunshine to the lives of others cannot keep it from themselves.—*James M. Barrie.*

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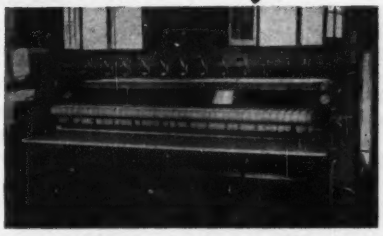
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With the Auxiliaries

St. Paul's Auxiliary, Saskatoon, Reports on Successful Year

Members of the women's auxiliary to the St. Paul's Hospital, Saskatoon, Sask., report that, due to the excellent support given by the public and the enthusiastic work of the 142 members, the past year was most successful. Activities included a tag day, at which $2,241.64 was realized; a membership tea; two rummage sales; a pussy willow tea, which also included a home cooking and candy sale; and the sale of 150 cook books.

Regular projects maintained by the auxiliary are: Christmas presents for the hospital patients; donations to the cancer fund and Crippled Children's Hospital; a mobile library service; and the awarding of a medal to the nurse graduating with the highest marks in nursing theory. Special projects for the year were the purchase of chrome chairs for the cafeteria and steel over-tables for the public wards. A hairdresser was also engaged for the hospital and a $200 scholarship was allotted to enable a nurse to take a post-graduate course.

* * * *

New Auxiliary Formed at Ormstown, Quebec

An enthusiastic group of some 75 ladies met recently to organize a women's auxiliary to the Barrie Memorial Hospital, Ormstown, P.Q. Officers were elected and the group plans to have three meetings yearly. Active and associate membership was set at $1.00, while life membership was set at $25. At the close of the meeting some 50 active memberships and one life membership were received. A door-to-door drive will be undertaken to enlist new members.

* * * *

Membership Reaches All-Time Record

An all-time record of more than 1,300 members was reached after the women's auxiliary to the Port Arthur General Hospital, Port Arthur, Ont., completed a membership drive. At a recent meeting the president of the auxiliary gave a report of the annual convention of the Ontario Women's Hospital Auxiliary Association, which was held in Toronto at the end of October.

* * * *

Auxiliary to Purchase Linen for Willett Hospital, Paris, Ont.

The women's auxiliary to the Willett Hospital, Paris, Ont., has voted $100 for the purchase of linen for the hospital. During the Christmas season, presents were distributed to the public wards and turkeys were purchased for the hospital's Christmas menu. The auxiliary also donated the articles, left over from a recent rummage sale, to the Salvation Army.

* * * *

Aid to Rocky Mountain House, Alta., Has Enviable Record of Service

An enviable record of service has been achieved by the women's auxiliary to the Rocky Mountain House Municipal Hospital, Rocky Mountain House, Alta. Some of the articles the auxiliary has purchased, since March 1950, include: bedside tables, $143.26; paint, $50.00; lamp, $41.89; ash tray stands, $16.25; stainless steel coffee pots, $77.36; bassinet, $32.35; baby clothes, $56.97; tray carrier, $116.00; over-bed tray, $44.00; and dishes and bed throws, $100. At a recent tag day the auxiliary raised $109.

* * * *

Active Year for Auxiliary at Roblin, Manitoba

The annual report of the ladies' aid to the Roblin District Hospital, Roblin, Man., which has a membership of 44, showed a bank balance of $1,421.73. During 1951, money received from fees, donations, and functions, amounted to $550.44. Groups of women, from the district served by the hospital, meet periodically to can fruit. A total of 800 quarts of preserves were provided in this way. A shower of jams, jellies, and pickles was held in the fall.

* * * *

Auxiliary Contributes to Hospital Building Fund

The women's auxiliary to the Hanover Memorial Hospital, Hanover, Ont., recently donated $1,000 to the hospital's building fund. During 1951, a total of $1,286.14 was raised. This amount was derived from teas, a "hope chest" draw, and a tag day. Some of the projects undertaken by the auxiliary were: the purchase of linens for the hospital, painting and decorating, Christmas presents for the patients and nurses, and the purchase of four woollen blankets.

* * * *

Auxiliary to Open Snack Bar

A snack bar and gift shop will be opened shortly by the women's aid at the Kingston General Hospital, Kingston, Ont. The gift shop will be stocked with articles made by patients in the occupational therapy department and by members of the auxiliary. They also plan to sell small toilet articles. The 400 members of the auxiliary will take turns staffing the snack bar and gift shop.

* * * *

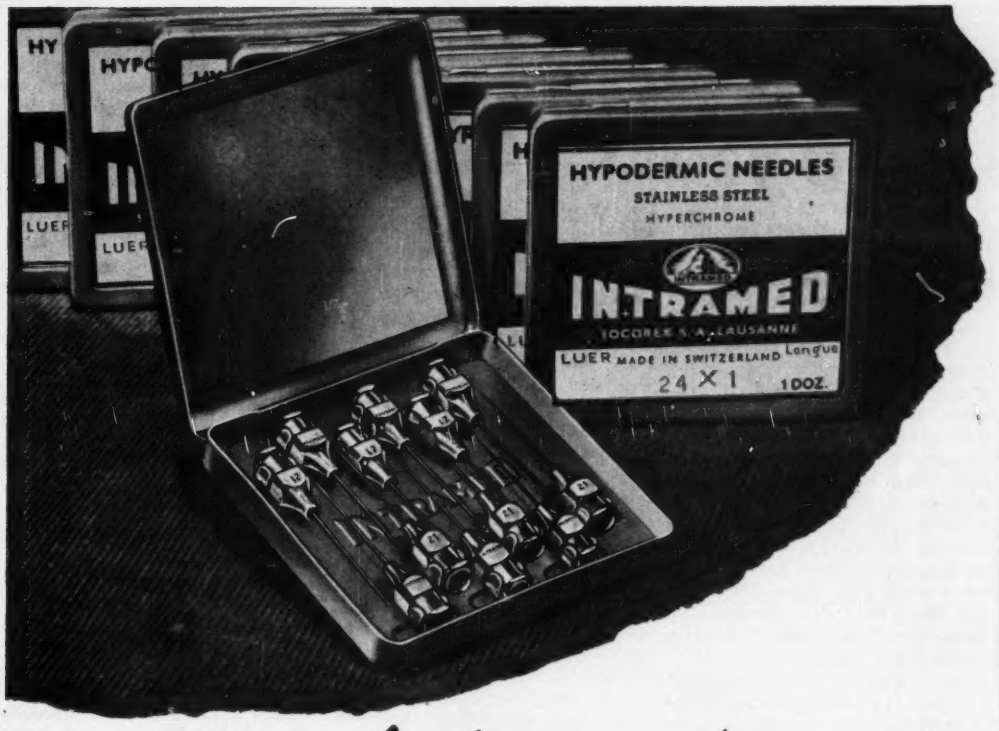
Auxiliary Donates $400

A donation of $400 was presented to the Victoria Hospital, Prince Albert, Sask., by the ladies' auxiliary and it will be used for the children's ward. The annual Christmas tea and bazaar was held at the end of November and a handmade wool rug, which had been donated to the auxiliary, was raffled. The treasurer's report showed that over $1,000 was raised during the past year.

* * * *

Laboratory Equipment Purchased

Special laboratory equipment, valued at $5,000, has been presented to the Calgary General Hospital, Calgary, Alta., by the ladies' auxiliary. The equipment was purchased with funds raised at a raffle of a car last spring.



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Notes on Federal Grants

Construction

Hospitals in Winnipeg, Virden, Morden, and Sandy Lake, all in Manitoba, have been awarded federal grants totalling more than $462,000. The largest grant, for the new Children's Hospital, Winnipeg, is $334,000. When completed in 1953, this hospital will have 266 beds. A grant of more than $47,500 has been allotted to the new Virden District Hospital and, when it is completed next summer, it will have 34 beds and a 10-bassinet nursery. The new hospital at Morden will replace an obsolete building and will receive a grant of more than $73,300. The grant for the Sandy Lake Hospital will be $7,500. This unit, which will serve about 2,800 people, will be opened shortly. It will have space for four beds, a three-bassinet nursery, a doctor's office, and living quarters for the nursing staff.

The new Hodgeville Union Hospital, Hodgeville, Sask., which was completed recently, has been awarded a grant of $8,000. It has space for eight beds, an operating room, and a doctor's office.

Crippled Children

The training centre for cerebral palsied children, which opened early last year in Hamilton, Ont., has been allotted $10,000 from federal health funds to assist in developing its services. Opened in April by the Hamilton District Society for Crippled Children, the centre is at present training more than 40 children. The federal grant will be used to help pay the salaries of specialists for the training centre's staff.

A federal grant of $10,000 has been allocated to the Cerebral Palsy Society of Ottawa and District. The society opened a training centre last April, which can accommodate 15 to 20 children.

To help provide better treatment facilities for crippled children in Quebec the Rehabilitation Society Inc., Sherbrooke, will establish an orthopædic centre with financial support from federal health grants. In addition to providing treatment for children under the society's care, the centre will also serve other children who need this type of assistance. It will be staffed by a full-time masseur-instructor in physical education and part-time by a doctor trained in orthopædics. The federal grant totals $5,575.

To assist in developing a program of assistance for crippled children in Nova Scotia, the federal government is underwriting the establishment of a brace-maker's shop in Halifax. It is expected that the shop will be of considerable assistance to the Rotary Clubs, the Junior Red Cross, and other organizations which have generously supported work among crippled children. The grant of $11,900 provides for the capital cost of equipment and the salaries for two men who will operate the shop.

Public Health

A new course to train technicians for hospitals, sanatoria, and other public health institutions has recently been organized by the faculty of medicine, Laval University, Quebec City. Designed to overcome the shortage of competent technicians, the full course requires two years' training with practical experience in university and hospital laboratories to supplement the lecture courses. The federal government is supporting the new project with a grant of more than $54,000. This amount provides for a quantity of scientific apparatus needed for the additional students and for part of the salaries of the director of the course, the assistant director, and the teaching staff. The school year will be 50 weeks of which 30 will be for lectures and laboratory practice at the university and 20 weeks for work with technicians already employed in hospitals.

Purchase of a new mobile public health laboratory, to serve rural areas of Ontario, has been authorized by the federal government. The mobile laboratory will be used mainly for emergency work in country districts and will supplement Ontario's system of regional provincial laboratories. The grant, totalling more than $15,800, covers the cost of the laboratory and equipment and the salaries of a bacteriologist and a laboratory technician to man the new unit.

To help improve the public health services, particularly public health nursing, federal funds have been allocated for special training courses in Ontario. Funds have been set aside for two regional conferences for supervisors in local, official health services. The provincial division of public health nursing is planning the discussion program which approximately 60 nurses are expected to attend. Eastern Ontario supervisors will meet in Peterborough and those from Western Ontario will meet in Brantford this month.

Federal funds are also being used to give nurses who join public health nursing services in Ontario a two weeks' orientation course before they begin their new work. Approximately 40 nurses are expected to take this training during the year. These courses were inaugurated in 1950 and have proved to be of value.

Research

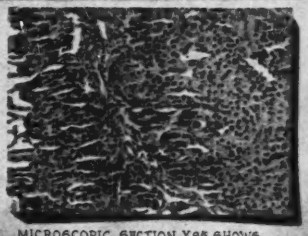
An investigation into the prevalence of glandular diseases among school-age children is being carried out by the Hospital for Sick Children, Toronto. The study is being directed by Dr. A. L. Chute, physician-in-chief of the hospital's department of paediatrics and is being financed by a federal grant. Arrangements have been worked out with school doctors in the Greater Toronto area to notify the research group of any child in their school who is thought to have any type of glandular disorder. With the consent of the parents, the child is then referred to the hospital's clinic where he is given a thorough physical examination



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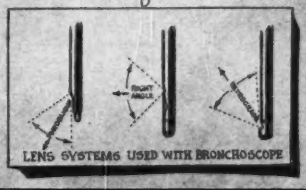
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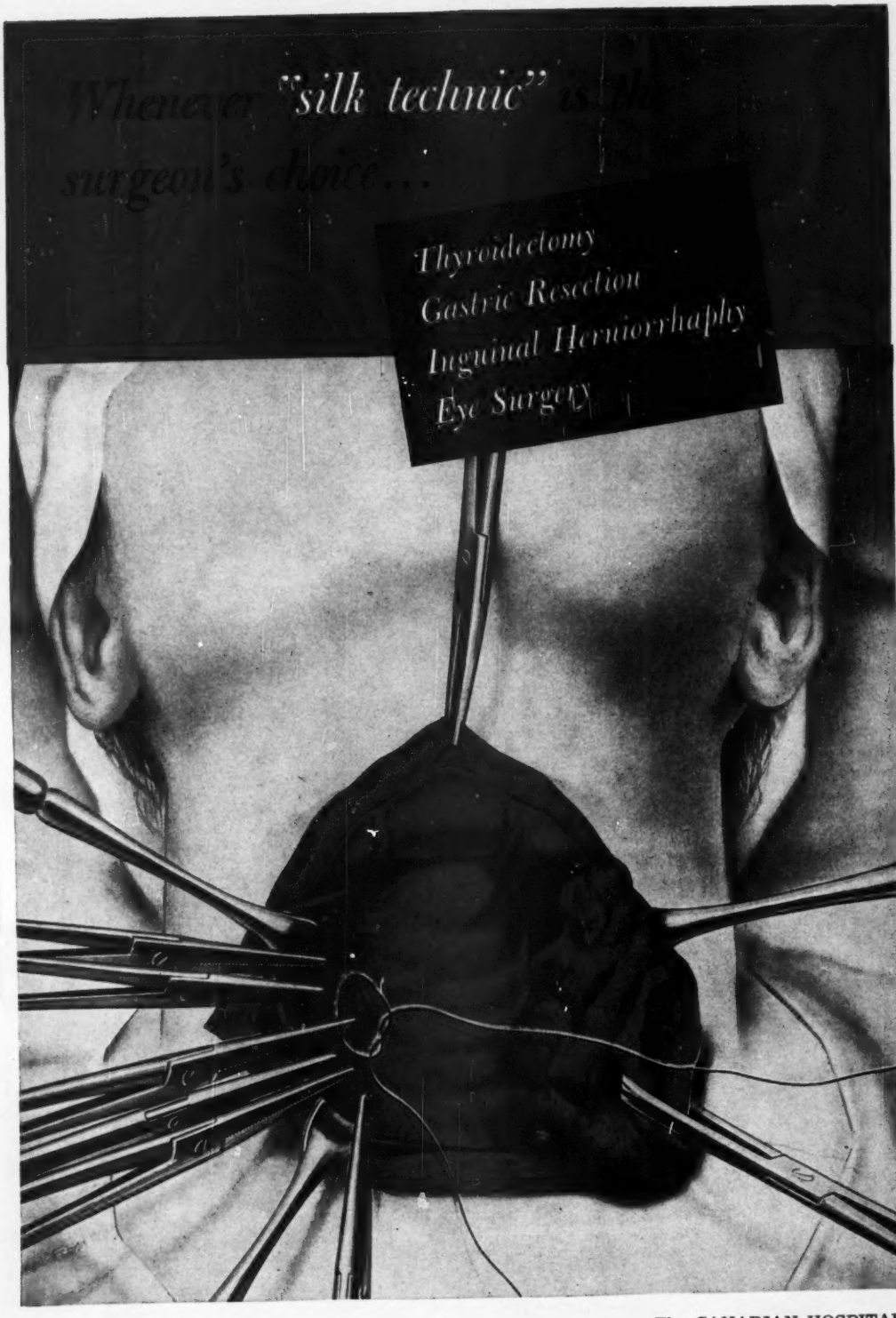
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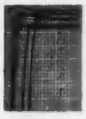

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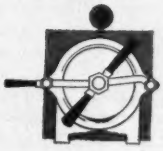
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and laboratory tests are made to determine accurately the nature of the disorder .

The federal grant of $11,550 covers the cost of special scientific equipment for the project and the salaries of a research assistant, two technicians, and a nurse. The whole study is expected to take about two years to complete.

Plans to expand tuberculosis control measures in Ottawa and Eastern Ontario are being aided by newly-approved grants. To date the provincial chest clinic office in Ottawa has not been able to organize regular x-ray clinics in a number of smaller centres in Eastern Ontario because of a lack of transportation facilities for portable x-ray equipment. Purchase of a vehicle for moving the x-ray machines from place to place will permit clinics to be held in 15 additional towns and villages: Cobden, Killaloe, Whitney, Calabogie, Griffith, Jasper, Lanark, Carp, Spencerville, Riceville, St. Eugene, Vankleek Hill, Alfred, Osgoode, and Russell.

A second grant helps to provide for the salaries of a physician to act as full-time director of tuberculosis control with the Ottawa city health department and for an additional public health nurse for the tuberculosis clinic. In addition to looking after the public health aspects of tuberculosis control for the city, the full-time director will also administer the anti-tuberculosis dispensary for the Ottawa Anti-Tuberculosis Association and will maintain close liaison with the Royal Ottawa Sanatorium.

Tuberculosis

A broadened program of B.C.G. vaccination for groups of people who have greater than average opportunity of becoming infected with tuberculosis is being undertaken in Manitoba with the financial support of a federal health grant. As part of the new program a B.C.G. vaccination service is being organized to include student nurses in all general hospitals; all staff members in sanatoria and mental hospitals; tuberculosis contacts; and other persons who request vaccination or are recommended for it by their physician.

The expanded use of B.C.G. will be handled through the Central Tuberculosis Clinic in Winnipeg. Most of the vaccinations will be given there but supplies of B.C.G. will be issued to hospital laboratories and sanatoria for specific purposes. The federal grant of $4,000 will meet the costs of the initial tuberculin testing, including tuberculin inoculation and reading, vaccination with B.C.G., and the subsequent tuberculin test to establish the results of the vaccination. The new program is being undertaken on the recommendation of the medical director and the medical advisory committee of the Sanatorium Board of Manitoba.

Fellowships have been set up to train three pathologists and a grant has been authorized for the salaries of a nurse-instructress for the Niagara Peninsula Sanatorium, St. Catharines, and for the Ongwanada Sanatorium, Kingston. The addition to the staff of a nurse, trained in tuberculosis control and qualified to teach, will enable these sanatoria to train student nurses from general hospitals in St. Catharines, Niagara Falls, Kingston, Belleville, and possibly Peterborough.

To help provide prepaid x-ray services in the Morden, Man., hospital district, the federal government has allotted funds to buy the required equipment. This is the sixth Manitoba hospital district to receive federal aid in setting up prepaid laboratory and x-ray services. The equipment will be located in the Manitou medical nursing unit. Owing to the lack of qualified staff, the complete prepaid service cannot be inaugurated at present but, in the meantime, the x-ray equipment will be operated at cost as a service to residents of the area.

Executives Need Courage

Many a brilliant idea has been lost because the man who dreamed it lacked the spunk to put it across. The budding executive who finds that he is too conservative should practise taking chances in a small way until he gets the feeling of self-confidence that comes from exercising initiative. The courage he is seeking is not mere absence of fear. He who realizes clearly all the risks involved, and decides to go ahead with his plan, is a courageous man in the best sense of the word.

Bravado is to be equally censured with cowardice. The ill-considered acceptance of any and every risk has no part in the essence of courage. The executive must have the power of decision. Life is constantly confronting us with a series of choices. We cannot avoid deciding, because even to seem to make no choice at all is in itself to choose not to decide.

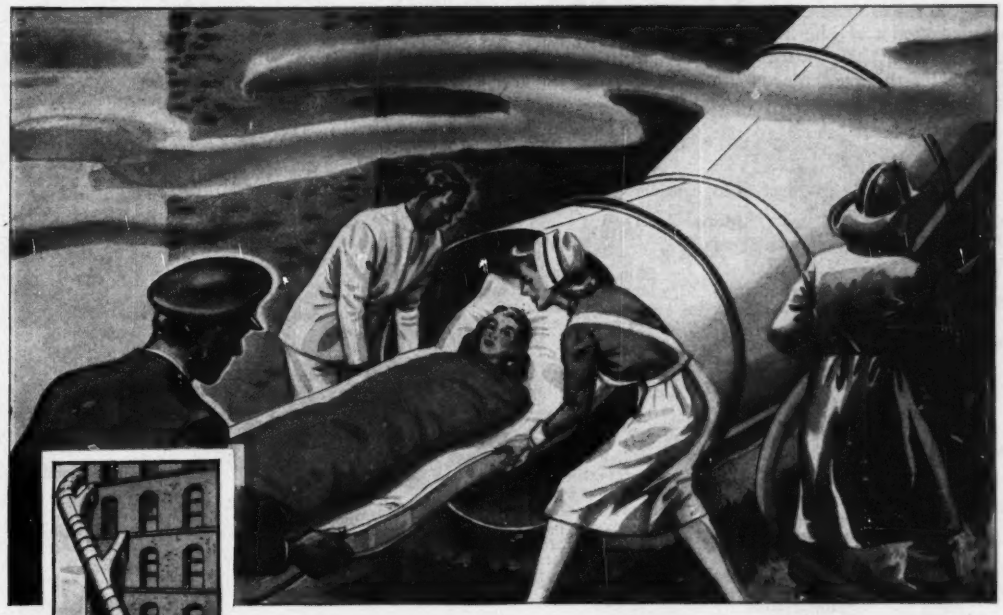
It is not required that the executive make decisions in rapid-fire succession, though this seems to come naturally to some men. More crucial is the ability to arrive without dithering at a decision that is wise. This is one of the traits watched in a man when he is being considered for promotion: does he come to his boss *with* decisions or *for* decisions? The man who says "Do you want to do so and so?" is trying to use the head of the man above him. Some weaknesses can be covered up by superior qualities in other spheres but if a person is not certain and decisive he has only dim prospects of becoming a good executive.

Administrative ability is taken for granted as a necessary quality. In a great many businesses it is more important than technical knowledge. The good administrator is able to develop an organization and keep it working purposefully and harmoniously.

The good executive leaves his emotions at home and only his family knows of his temperamental upsets. It is a sad day for the rising executive when his secretary warns his subordinates: "Don't go near Mr. Blank today—he is in one of his moods".—*"The Royal Bank of Canada Monthly Letter", October 1951.* •

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Epidemiology in General Hospitals

(Concluded from page 30)

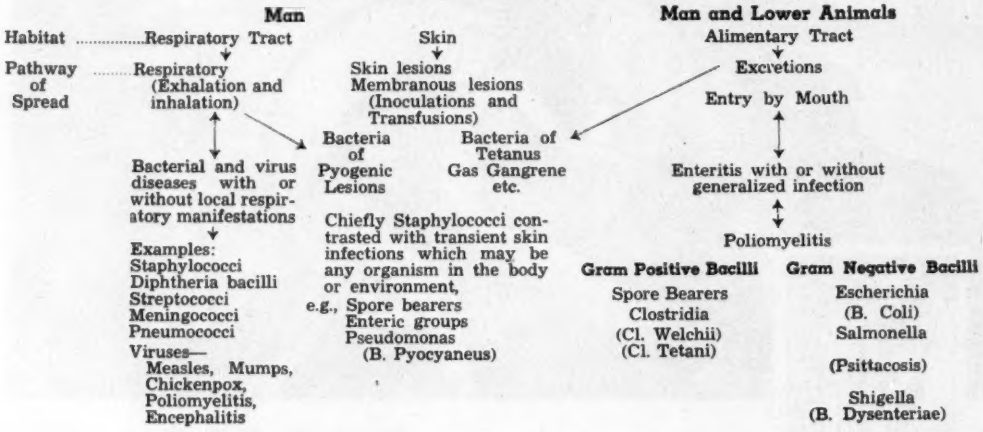
groups or bacteria and viruses in general is far beyond the scope of this paper. For instance they may be classified and identified as to their shapes, their cultural characteristics, their resistance to antibiotics, their means of propagation, their utilization of sugars, their staining properties, et cetera. Identification and classification is essential if the administrator is to cope successfully with hospital infections but this is the job of a trained and experienced bacteriologist. For our purposes a simple classification of bacterial and virus infections will be sufficient.

This introduction has been designed to give administrators who have not had any training in epidemiology or bacteriology a little appreciation of the rationale behind standard hospital procedures designed to prevent the spread of infection. The rest of our discussion will be concerned with an outline of those procedures.

(To be concluded next month)

Bacterial Infections

(Most easily considered in relation to the normal habitat of organism)



Off With the Old On With the New

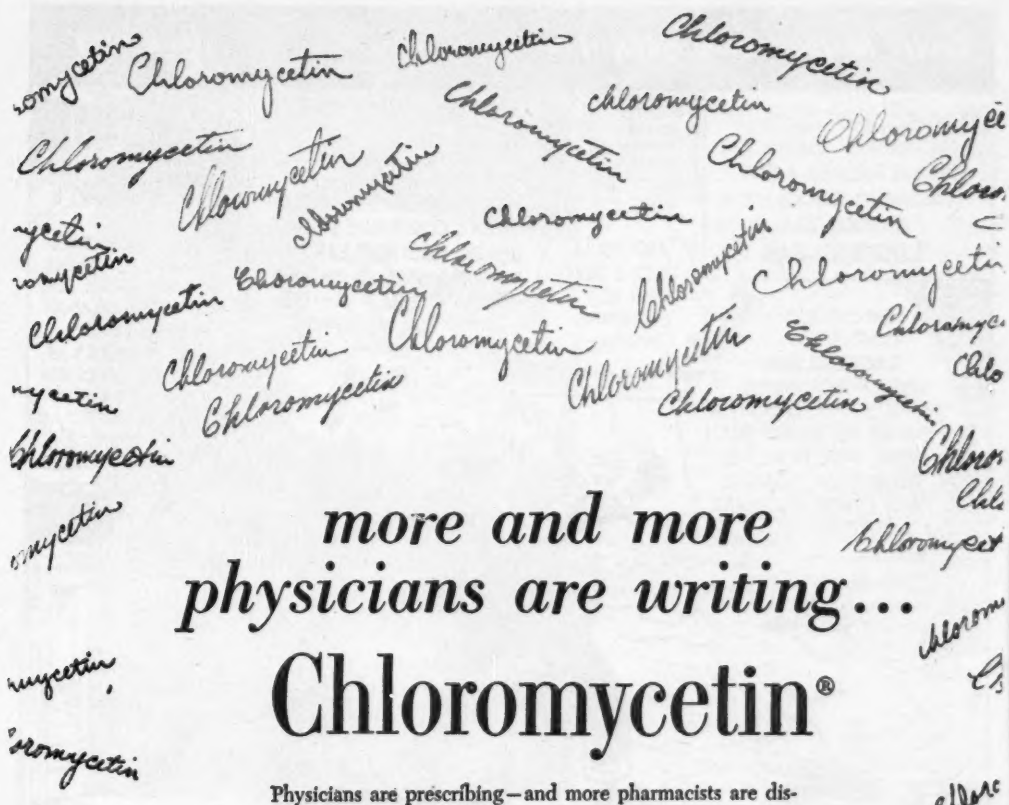
Workmen recently filled in the lettering on the façade of Montreal's Homoeopathic Hospital, which spelled out the old name, and superimposed the new name, The Queen Elizabeth Hospital of Montreal. Permission to change the hospital's name was accorded by His Majesty the King and Her Majesty the Queen. Although the name has been changed, there will be no change in the location, administration, personnel or policy of the hospital. This change was the result of a feeling that the term "homoeopathic" did not describe correctly the current hospital policy. Today about 60 per cent of the admissions are surgical cases, 25 per cent are maternity patients, while only 15 per cent are medical cases.

The hospital's history dates back to 1863, when the Montreal Homoeopathic Association was organized by some prominent citizens of that city. In 1865 a charter, which is still in force, was granted to the association, giving it authority to establish a medical college and a hospital and to grant licences for the practice of homoeopathic medicine.

Interest in homoeopathy, which advocated careful individual study of the patient and the prescription of very small doses of single drugs, grew. In 1893, efforts were made to secure hospital accommodation for patients who wished this type of treatment. When petitions for accommodation in other hospitals failed, homoeopathic supporters decided to open their own hospital. A contribution of $10,000, in addition to other donations, made possible the purchase of a building for $8,000, on the corner of McGill College avenue and Burnside Place. A new wing was added for $4,000 and, in October, 1894, the Homeopathic Hospital of Montreal was opened.

The Phillips Training School for Nurses was established in connection with the hospital and the first class of two nurses graduated in 1896. Since then the hospital has trained more than 450 nurses.

As a result of its first public appeal in 1925 the hospital was able to move, in 1927, to its present building. In 1938, following another successful campaign, the nurses' residence and interns' quarters were added and patient accommodation increased. Although homoeopathic medicines are still available, the hospital is equipped to give a general treatment and maintains a large outpatient and emergency department. A building program is under consideration.


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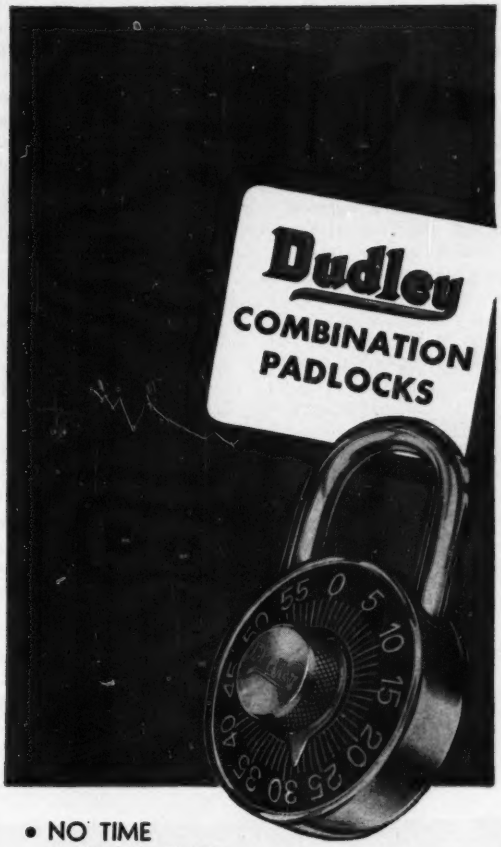
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Alexander Fraser Moffat

Treasurer of the Ottawa Civic Hospital and a director of the Ontario Hospital Association, Alexander Fraser Moffatt died in Ottawa on Sunday, December 16th, in his 43rd year. He is survived by his wife, two sons, and a daughter.

Mr. Moffatt was born in North Sydney, N.S., was a graduate of the University of Saskatchewan, and began his career as a chartered accountant. He joined the staff of the Ottawa Civic in 1942. An alert and enthusiastic worker, he was among those appointed by the Canadian Hospital Council to represent the hospitals of Canada at the 1949 Dominion-Provincial Conference on Hospital Statistics. He was the first chairman of the O.H.A. accounting section and contributed much to the organization of the accounting institutes held by that association in 1950. Mr. Moffatt was also second vice-president of the American Association of Hospital Accountants.

Gesture of Friendship

A block of stone, inset with the metal coat of arms of the world-famous St. Thomas Hospital in London, England, is being sent as a gift to the new St. Thomas-Elgin General Hospital, St. Thomas, Ontario. The St. Thomas Hospital, London, where Florence Nightingale trained as a nurse, is one of the oldest hospitals in the world. It was founded on the south bank of the Thames River, in 1106, at the time St. Thomas à Becket was canonized.

During the Second World War, the London hospital was heavily damaged by bombs. The cubic foot of stone that will be built into the hospital in Ontario has been taken from one of the bombed buildings, as well as the coat of arms. Rebuilding plans for the English hospital have been approved and construction will begin shortly.

Take away from our hearts the love of the beautiful and you take away the charms of life.—*Rousseau.*

Chronic Illness

(Concluded from page 35)

earns them a star in heaven, forgetting that *how* they visit the patient is the important thing. All should ask themselves when they leave: "Have I left the patient happier, or have I magnified or let her magnify her physical and mental problems?" People are people, sick or well, and as such may magnify problems at any time. When ill, such a tendency is bound to be accelerated; yet many visitors are apt to add fuel to the fire and by the time they leave, the patient is convinced that her lot is indeed a hard one. This type of person often influences other visitors so that they too come to sympathize rather than to cheer.

How many people stop to realize that two visitors at one time are as many as any patient can entertain conveniently? Do not leave the patient, who is your hostess, the decision or embarrassment of answering "Am I tiring you" or "Do you wish me to go". Decide this essential question and go. Be sure that you are there to entertain the patient rather than to be entertained yourself.

As a visitor, you must realize that the patient needs a period of time between your visit and her meal tray. If you have the patient's welfare at heart, you will give her an opportunity to receive nursing care in this interval. See that your visit is a refreshing breeze from outside, not a cold wind or a strain to be endured.

The official visitor must also be careful about asking questions concerning the patient's condition. If the patient wants you to know, let her tell you and let her or her family tell it to others. Please do not ask nurses questions concerning the patient as it is not their place to discuss patients' diagnoses with strangers.

Besides visiting patients, there are many other invaluable services that a volunteer group can perform. Before discussing these I would like to emphasize that the essential qualification a volunteer worker should possess is dependability. By this, I mean that the volunteer will make sure that she is at the hospital at the time specified and does the task specified in a regular not spasmodic fashion.

A ladies' auxiliary may give definite service to patients suffering from extreme disabling illness through organized "feeding" groups. In my hospital we have 172 patients who are quite unable to feed themselves. When you consider that these patients must have three meals a day, extra nourishments, and medicines, you will have some idea of our problem. Even a drink of water must be served. Such patients do not eat quickly and, of course, it is impossible to have a nurse for each one of these people. Hospital personnel today see no reason why they should not have decreased working hours as well as employees in other industries. Because hospitals must have a staff on duty twenty-four hours a day, seven days a week, the personnel problem is often a grave one, regardless of increased expense.

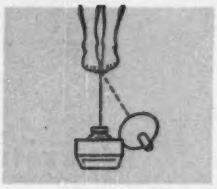
When I hear well meaning people try to explain why a hospital serving chronically ill patients can be administered more cheaply and with fewer staff than one serving the acutely ill, I am amazed. I know that at my hospital patients can do less for themselves than in an acute hospital and there are so many utterly helpless that additional staff is needed. The staff in a chronic

(Concluded on page 82)



At concert time beds are wheeled into the auditorium at The Queen Elizabeth.





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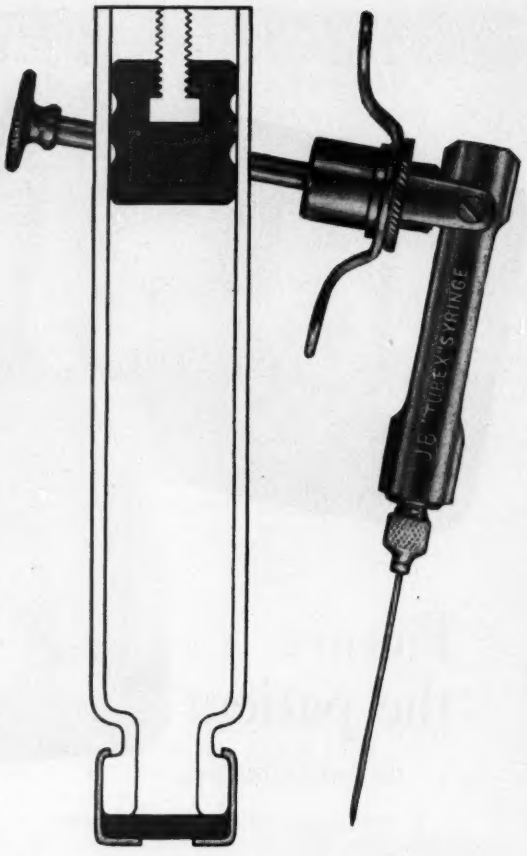
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hospital is very important and just as expensive as anywhere else. Acute hospitals can charge for many services chronic hospitals must provide for very little, or nothing, because patients have so often used their money before they come to us.

For our patients' enjoyment, we have an auditorium, sun-rooms, a beautiful garden in summer, et cetera; but in order that they may enjoy these, it is necessary to move them. This is a situation where volunteers can perform another service and, at our hospital, there are organized groups for moving patients under the direction of the nursing office. Care and arrangement of flowers offers another opportunity for volunteer service.

Library service can greatly benefit the chronically ill. A ladies auxiliary may be able to influence the community library board to provide this service as well as a librarian. So often chronic patients are thought of as those who are too old and infirm to enjoy anything. I am speaking of prolonged illness. There is nothing more important therapeutically than a good book which is carefully chosen by one who knows how to consider size and weight as well as content. Constant or prolonged association gives the librarian an insight into the tastes, hobbies, et cetera, of different people. Too many books that are found in hospitals are discards from somebody's attic. As with physiotherapy and occupational therapy, books must suit the needs of the patients to give results.

Public Relations

Besides giving direct service and providing material comforts, such as money can buy, hospital auxiliaries also play an important part in public relations. They can interpret hospital management to patients and the public in such a way that friction and dissatisfaction can be largely eliminated. Auxiliaries can influence those in charge of building new wings. So often, when a new wing is built, it is planned to leave chronic patients in the old building. Thus acutely ill patients who are hospitalized for a shorter period receive all the benefit of the new building with its large windows, prettily coloured walls, et cetera, rather than the chronically ill patients who must remain in hospital indefinitely. Perhaps we should all stop to think about this situation more seriously, not overlooking the fact that someday *we* may be among the chronically ill.

A very important phase of chronic illness occurs when patients reach the state when they should be patients no longer. Many have to learn a new trade or must return to their previous type of work very gradually since prolonged illness leaves them completely unable to cope with normal employment. Residential, sheltered work shops gives these people an opportunity to make this adjustment. Auxiliaries can be of immense help in providing, or influencing others to provide, these workshops. Unless ex-patients from acute and, especially, chronic hospitals can be prepared to return to work with some remuneration, the community will become too overloaded with illness and the economic burden will be unendurable.

In a study report on chronic illness, it was found that as men and women remain in hospital there is a progressive decline in their morale (yet hospital boards advocate that these people should occupy the old hospital as a new one is built). After four months, the report indicated, it is difficult to persuade a patient to face the outside world, after a year it is almost impossible. It was also stated in this report that chronic rheumatic patients would not stir a finger to help themselves if a nurse was within call. If the word "discharge" was mentioned, new pains and aches made their appearance instantly. The thought of going home appalled these people. This report re-emphasizes the necessity of residential, sheltered work shops and points out the importance of an intense study of prolonged illness.

Volunteer groups have a share in this task of emptying hospital beds of all types so that they may be available for those who have greater need of them. The solution to this problem does not lie in obtaining more and more beds but rather in keeping patients moving back to health and self support.

In conclusion, I would like to refer to Tennyson again. As in the case of Ulysses, we must have the determination "to strive, to seek, to find, and not to yield" until we find the solution to this great problem and great need.

Pharmacopoea Internationalis

Volume I of the first international pharmacopoea has been published by the World Health Organization. Work on the drafting of an international pharmacopoea began in 1937 under the auspices of the League of Nations Health Organization. Interrupted by World War II, the work was not resumed until 1947 when the WHO Expert Committee on the Unification of Pharmacopoeias was set up.

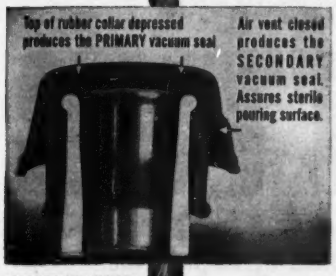
The *Pharmacopoea Internationalis* is similar in form to the present-day national pharmacopoeias. Volume I, in addition to 199 monographs giving specifications for drugs and preparations, including certain newer substances such as antitoxic sera and the sulfa drugs, contains 43 appendices in which reagents, test solutions, solutions used for volumetric analysis, weights and measures are defined; biological assays, determinations of potency, and limit tests for various metals and salts are described; the international atomic weights of elements mentioned in the volume are listed; and the usual and maximal doses of drugs for adults are tabulated. A section, entitled "General Notices" defines the descriptive terms used for solubilities and containers; and general observations on nomenclature, galenicals, molecular weights, interpretation of figures, chemical and graphic formulae, assays, et cetera, are given.

The price of Volume I is $5.00. It can be obtained from the Ryerson Press, Toronto, Ont. •

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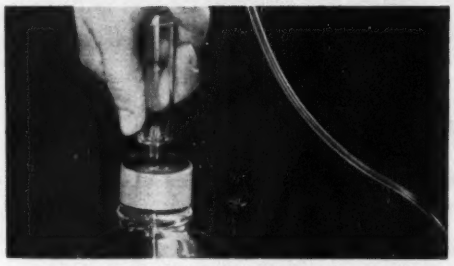
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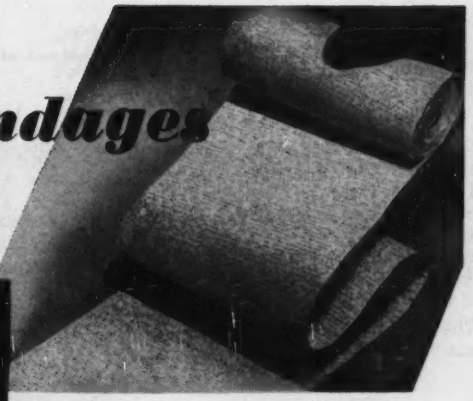
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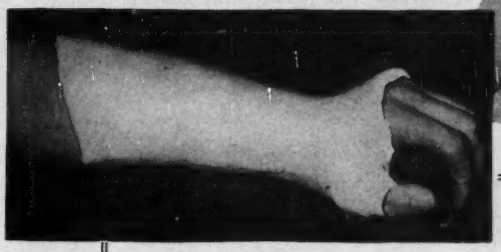
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Special Reports

(Concluded from page 37)

and billings with those furnished to paying patients.

Other Special Reports

Other special reports which may prove helpful in the administration of hospital operations are: analysis of consumption of supplies by departments; occupancy rate comparisons; comparative food consumption report; and residence of patients report.

The accountant and the administrator should discuss the entire reporting picture so that the administrator fully understands what reports can be obtained and the accountant understands what information the adminstrator wants. Financial reports of a special nature which the administrator may need from time to time should be kept at a minimum. Amendments to special reports should be made as changing conditions warrant. Above all, reports should only be prepared if they are used.

Form E

Analysis of Slow Moving Inventory Items, June 30, 1951

Description of Item	Quantity on Hand	Quantity Consumed in Past Three Months	Anticipated Period to Exhaust Quantity on Hand	Comments
Surgical Gloves —Size 10	20 doz.	2 doz.	30 months	
Elastic Bandages — 3" Wide	98 bandages	18 bandages	16.3 months	

Form F

Analysis of Special Services Rendered to Indigent In-Patients, June, 1951

	Medical & Surgical Patients			Obstetrical Patients		
	Total Billings*	Number of Patient Days	Billings Per Patient Days	Total Billings*	Number of Patient Days	Billings Per Patient Day
Laboratory						
Paying Patients	$762.60	820	$ .93	xxx	xx	xx
Indigent Patients	272.15	216	1.26	xxx	xx	xxx
X-ray						
Paying Patients	xxx	xx	xx	xxx	xx	xx
Indigent Patients	xxx	xx	xx	xxx	xx	xx
Pharmacy						
Paying Patients	xxx	xx	xx	xxx	xx	xx
Indigent Patients	xxx	xx	xx	xxx	xx	xx

*Based on similar rates for paying and indigent patients.

A Decade in Retrospect

(Concluded from page 43)

mission has grown. This important coincidence has the same effect on Blue Cross costs as it has on hospital expenses, to wit: the earlier an acutely ill patient is discharged, the sooner he is replaced by another acutely ill patient requiring costly concentrated care. The result is a constant chain of expensive care involving more nursing service, more laboratory service, x-rays, down a long line of integers known only too well by hospitals.

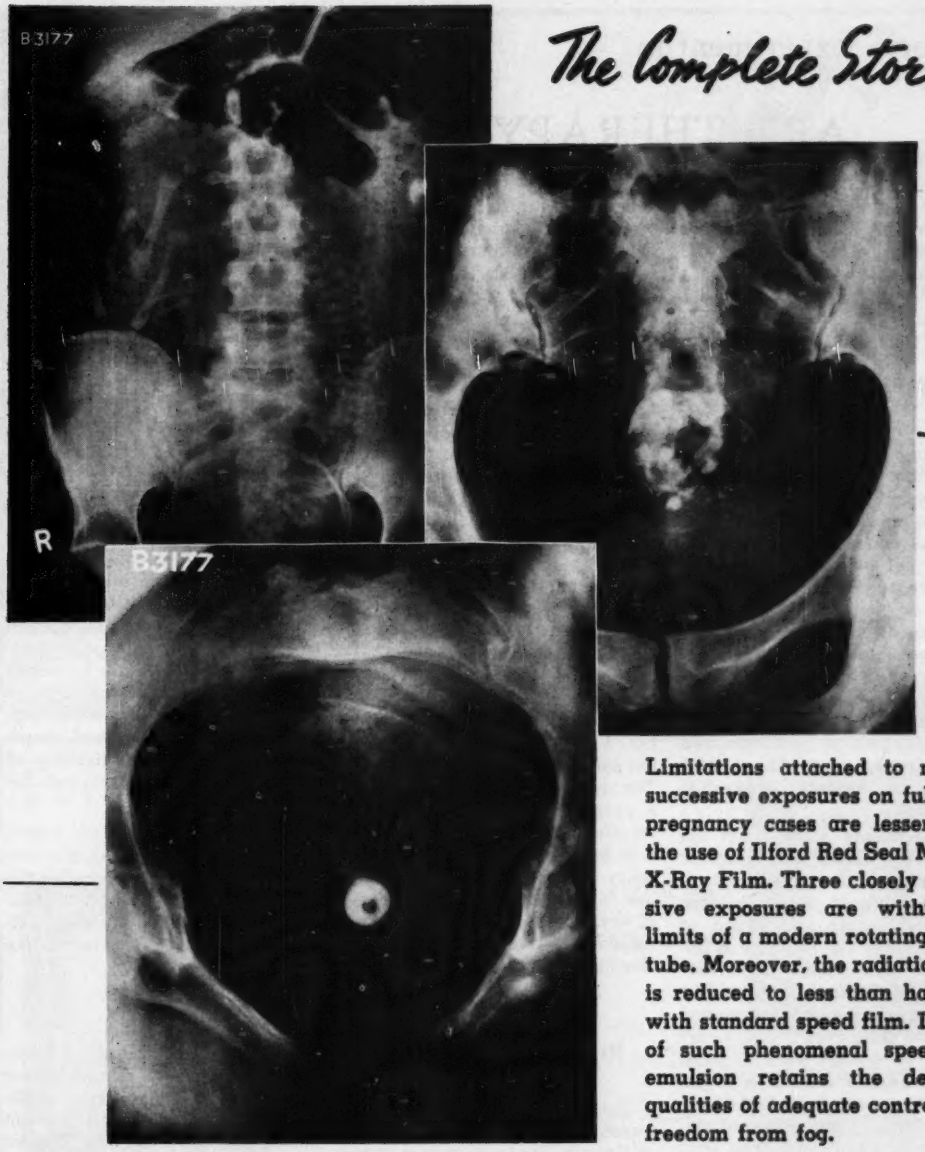
The solid line of Chart B tells its own story. Almost stable in the first three years of Plan operation, cost-per-day set its sights "on things above" toward the end of 1944 and has gone straight skyward ever since. By the end of June, 1951, it had reached 207 per cent. While it is true that the extension of benefits referred to above has contributed to increased per diem costs, the 207 per cent figure is more readily accounted for by looking at any hospital's costs over the same period and, more simply, by calling at the local grocer's for a dozen eggs or a pound of butter.

Chart C illustrates the comparative increase in hospitalization and adminstration expense *per participant* during the decade ending June 30, 1951. Looking at what is perhaps the most interesting line, we see that hospitalization expense per participant, starting at a figure of $3.70 in 1941, rose peak by peak to $10.60 at the end of June, 1951—and there is no indication that this line is going to proceed in any direction other than up. The incline is sharpest from the last quarter of 1946.

Adminstration expense, which started with an understandably high figure coincident with the launching of the Plan, reached an all-time low in 1945 then gradually worked upward to 1948 due to the influence of inflationary conditions.

A statistical report such as this is not complete until its comparative figures are considered in the light of the volume of service provided. Blue Cross in Ontario, with an enrolment of 1,526,461 participants as of June 30, 1951, serves one-third of the people of the province. While steadily rising hospital costs and utilization have a marked effect on Plan operation this large enrolment indicates that the general public realizes the value of the Plan as a prudent means of insurance against the cost of hospital care. It also affirms the significance of Blue Cross as an alleviating factor and possible panacea in hospital financing and community welfare.

The Complete Story



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Victoria Experiment in

ART THERAPY

ONE morning almost four years ago, the first boxes of paints were given to the would-be artists in Victoria, B.C., tuberculosis hospitals. At that time, art therapy was a novel term. Today, the words have a familiar ring in Victoria. In the beginning there were no supplies and no funds. Because of this, most of the work done during the past four years has been in water colour on the back of discarded wallpaper but special supplies of good paper and paint have now been purchased by interested friends. Oil paints, because they are more expensive than water colour or tempera, have been used less often. For a period of three months this year, money was advanced by the B.C. Tuberculosis Society as an experimental backing. With this money a salary was paid an instructor and much needed supplies were bought to replace makeshift equipment.

The demands made upon art therapy are varied and complex. To begin with, the problem of approach is difficult. When children are given paints and urged to make pictures the response is immediate. They take their materials and begin to create. But adults are bound by inhibitions and fears. The people who come to art therapy groups all want to paint but are usually afraid to begin. Naturally enough their first paintings are small tight copies of pictures they have seen. The first problem is to break down this wall of inhibition and set free the personality behind it. To achieve this, the student must gain power over his materials and acquire a knowledge of what goes into a work of art. So demonstrations and instruction in the handling of brush and pigment are given and prints of the world's great paintings by old and modern masters are studied and discussed. The student is also encouraged to paint on large surfaces as the free sweeping movements necessary to cover a large paper or canvas are more likely to bring about relaxation.

As time passes, it becomes evident that different people want different things from art therapy. To most it is just another way of putting in time, because painting helps to stimulate the imagination and so relieve boredom. If it does nothing more than this it has a very definite value.

But it does do more. The aim of art therapy in Victoria has been, from the beginning, the self-expression of the individual. It has tried to lead people away from boredom by freeing the imagination and so helping them achieve the satisfaction of self-expression. The desire to create brings about a unique delight experienced in no other way. Now and then there is a person whose definite sensitivity responds to colour and line and to him comes the artist's thrill of creation. Such a person is an inspiration to any group and usually his presence results in a burst of creative activity in others as well.

Most of the artists have never painted before. At first the majority of them want to be taught to draw and paint in the accepted academic way. When, because of ill-health, they are unable to put in the necessary time and hard work that such an ambition entails, the realization is apt to bring discouragement and a sense of frustration. Such a mental experience is bad indeed. Because of this, the aim has been to stress experiment and the fun of adventuring, especially with colour. Patients are encouraged to seek emotional release in this way. Many patients have been persuaded to try this and an experiment in creative painting, stressing the free, emotional study of colour, is now underway. Abstract paintings, full of colour and delightful design, are making vivid the drab hospital walls. The people who have had courage enough to brush on their paint with emotional abandon and are hardened enough to scorn the remarks of co-patients have had a lot of fun. They have also learned much about colour and the delights of self-expression in form and design.

It is all a lot of fun for everyone involved and no matter where or how the work is conducted the aim is always the same: relaxation through creation and self-expression. Victoria patients like it!

This article, written by Joyce Swannell, Art Therapist with the Victoria Tuberculosis Control Unit, appeared in "Canada's Health and Welfare" magazine, August, 1951.

New School for Male Nurses Opens in Winnipeg

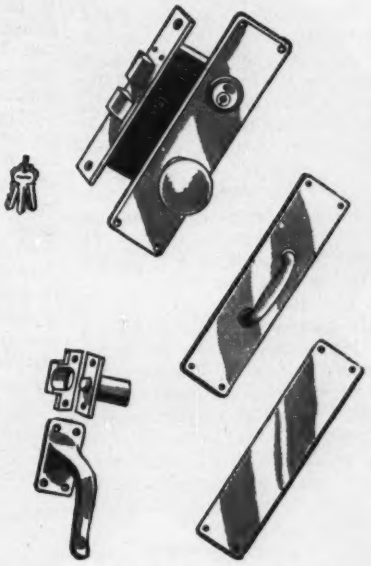
The first school to train male nurses in the west, one of three in Canada, has been opened at the Winnipeg General Hospital, Winnipeg, Man. Before World War II, schools for male nurses were operating in the United States but the field was virtually uncharged in Canada. In 1946, the Canadian Nurses' Association conducted a survey on male nursing in the Dominion and found only two provinces had schools to train male nurses — Ontario and Nova Scotia.

At that time, across Canada there were only 94 male nurses who had graduated from qualified schools. The situation was not much different in the United States. There were only 42 male nurses in the U.S. in 1945 but the number had grown to 719 two years ago.

Qualifications for male students who enrol in the Winnipeg course are the same as those for female nurses. They will pay for their own uniforms and books but will be provided with maintenance. No salaries will be paid but loans, where necessary, are made available by the government.

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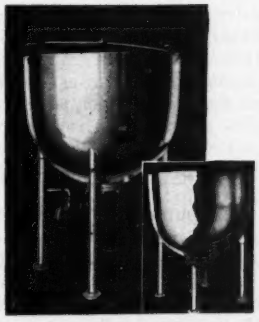
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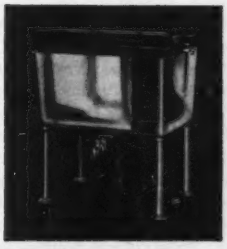
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(Suite de page 44)

un brave italien, le père d'une fillette de quatre ans à qui on est en train de faire quelques points de suture au bras. Il ne peut se résigner à rester à la salle d'attente et son attitude fait pitié à voir. Je lui demande comment l'accident est arrivé et il donne quelques détails, puis soudain, me regardant d'un air décidé: "Vas-y toé avec ma petite". Ce que je fis à la grande satisfaction du père et du personnel professionnel.

Un garçon de 15 ans, blessé à un jeu de hockey, meurt en arriveant à la salle d'urgence. La mère prévenue de l'accident se rend à l'hôpital et rencontre à la salle d'attente, le père qui lui dit brusquement: "Il est mort". Etant une cardiaque avancée, on peut imaginer la crise qui suivit cette déclaration.

Ces quelques exemples illustrent la nécessité de chambres de repos pour les membres de la famille du malade et les égards qu'il convient de leur témoigner.

L'Importance d'un Personnel Qualifié

L'officière d'admission à qui il appartient d'acclimater le patient à son nouveau milieu, partage avec le personnel de l'hôpital le but commun, à savoir, le bien-être de ce patient. Ce premier contact a la plus grande influence sur l'attitude que prend le malade pendant son séjour d'hospitalisation.

Aujourd'hui, où la formation du personnel hospitalier progresse à un niveau qui devient complexe, à qui confier ce poste important? Une infirmière, religieuse ou laïque, douée de qualités administratives, de persicacité et de discernement, qui s'y entend en finances, en sciences sociales, et qui de plus, possède des connaissances psychologiques du malade, est un sujet idéal, apte à exercer cette fonction avec compétence. Cependant, la réunion de toutes ces qualités étant assez rare chez une même personne, il faut compter sur l'expérience pour y suppléer dans une certaine mesure. Une connaissance pratique des autres services de l'hôpital, par exemple, à l'admission des patients aux cliniques externes, au bureau de la pharmacie, des rayons-x, du laboratoire et un stage d'observation à la salle d'urgence et dans un service de malades, aident beaucoup à la formation de l'officière en lui révélant l'hôpital en activité le rôle joué par chacun dans la grande organisation hospitalière et l'importance primordiale de parfaites relations entre tous dans l'exercice du rôle délicat qui lui est confié.

L'administration d'un hôpital désigne donc pour son bureau d'admission un délégué de confiance qui possède les qualités d'un diplomate, car c'est à ce délégué qu'elle confie sa réputation. Je suggère que l'officière s'engage par écrit au secret professionnel, secret auquel tout le personnel hospitalier est tenu; la clause du contrat peut se lire comme suit:

M. . . . s'engage à garder secrets, tous les renseignements ou informations quelconque qu'il peut obtenir, soit dans les filières de l'hôpital, soit dans les fillières du laboratoire ou de quelque médecin ou membre du personnel et à ne les dévoiler qu'aux personnes en autorité et qui ont légalement droit de les connaître.

La qualification est-elle suffisante en soi? Il faut admettre qu'une personne bien formée, bien préparée, fut-elle infirmière, assistante sociale ou comptable, religieuse ou laïque, n'est d'aucune valeur si elle ne possède pas un abord gracieux, un air affable capable de gagner la confiance du malade. On lui pardonne des erreurs techniques mais jamais on oublie une parole impatiente ou un manque de courtoisie.

Le manque de tact et l'attitude commerciale chez une officière sont également répréhensibles. Il faut savoir sourire pour faire le bien . . . sourire à tout le monde, surtout à ceux qui ne savent plus sourire.

Permettez-moi une digression. L'éditeur d'une critique sur les hôpitaux catholiques écrit le trait suivant.

Voulant rendre visite à un ami, un pauvre, je me présente à l'hôpital; on me répond que les visiteurs de la clientèle payante sont seuls admis par l'entrée principale. Je fus donc invité à me rendre à l'arrière de la maison et de me servir de l'entrée réservée aux malades non-payants; on me pria également de vouloir bien sortir par la même porte.

L'article continue . . . et le permis de visite me fut émis bien froidement. L'article s'intitule "L'Hôpital complexe d'aujourd'hui a besoin d'un coeur chaud," *(Hospital Progress, Avril, 1950)*. On insiste sur la présence d'une personne-clef à admission, rôle important d'avant-garde si nous voulons garder la bonne réputation acquise par les hôpitaux. On demande de se rappeler que le mot catholique, *i.e.*, universel, s'étend à tous les services de l'hôpital et à tous les malades sans distinction.

(à suivre en février)

* * * *

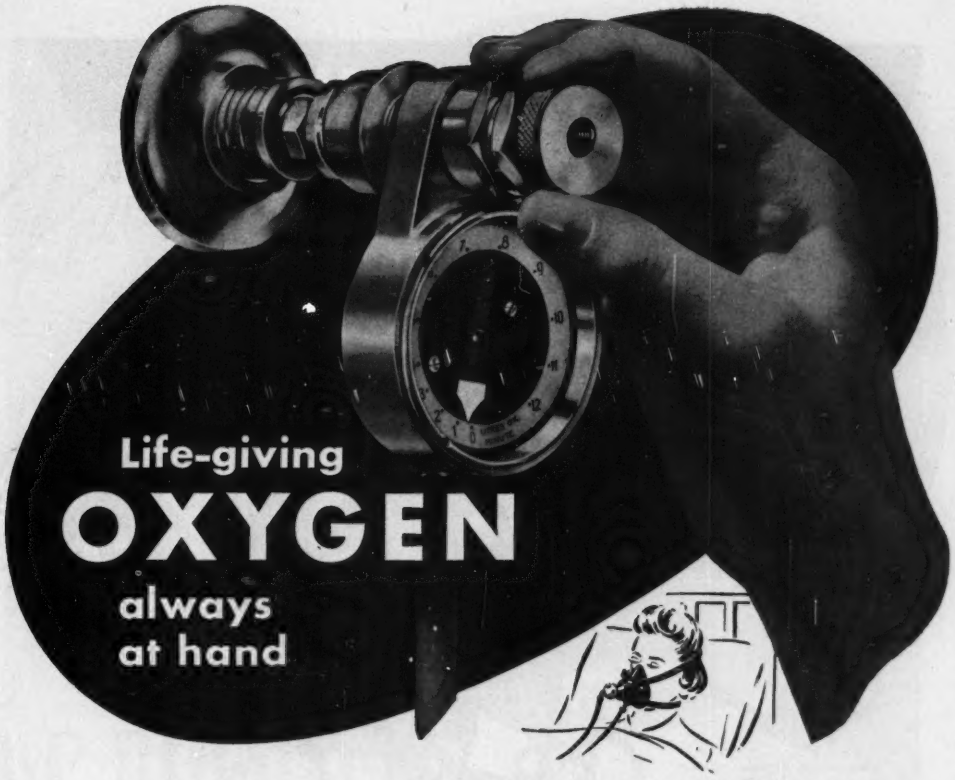
A Brief Résumé

The admitting office, considered to be one of the most important departments in the hospital, requires a well-qualified staff familiar with the policies determined by the governing board and all regulations affecting hospitals.

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If the reputation of the hospital rests upon the manner in which the sick are cared for, the courteous manner in which they are welcomed to the house of healing will have a great influence on the attitude of the patient during his illness. The use of an administrative manual, containing definite instructions issued by the administrator, is recommended if the admitting officer is expected to interpret to the public, to the hospital staff, to outside social agencies, the "personality" of the instituton.



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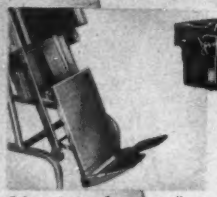
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"Standard Nomenclature"

As of January 2, 1952, the American Medical Association has made available to hospitals the new fourth edition of *Standard Nomenclature of Diseases and Operations*, published by the Blakiston Company, Philadelphia, Penn. Revision of the book was carried out by the editors under the general supervision of an Editorial Advisory Board and in collaboration with 24 committees representing each of the individual or specialty sections of the book.

Since its inception under the auspices of the New York Academy of Medicine and the First National Conference on Medical Nomenclature, in 1928, and the subsequent transferral of responsibility for its periodic revision to the American Medical Association, in 1937, the *Standard Nomenclature of Diseases and Operations* has grown rapidly. Although the dual topographic-etiologic coding system is not uncomplicated, it has demonstrated its flexibility both through ease of simplification for the small hospital and in ready expansibility for the large teaching and research hospital.

Because of the wide acceptance of this coding system and the fact that hospital record systems using the book must make the changes provided for in each revision, the editors of the fourth edition have made every effort to avoid changes that are not strictly required. Nevertheless, certain changes have become necessary in several sections of the book. These include: a complete revision of the psychobiologic section to bring it into accord with accepted diagnostc terminology of the American Psychiatric Association; a complete revision of the diseases of the Haemic and Lymphatic section to accord with newer thought in this field; and a complete revision of the section on tumor etiology.

For purposes of closer identification of two systems the fourth edition of *Standard Nomenclature of Diseases and Operations* has included an appendix cross reference of its code numbers to code numbers of the *International Statistical Classification of Diseases, Injuries, and Causes of Death*. The "International" code numbers have also been included parenthetically in the nomenclature section of the book. The main purpose of this has been to simplify the work of hospitals who do or may wish to participate in or contribute toward large scale state, nation, or world statistical studies of disease incidence. However, it must be emphasized that, for the purpose of hospital recording, the systems are by no means interchangeable. The "Standard" system, as a clinical system, is necessary for the proper separation of individual differences in disease for recording and research purposes, whereas the "International" system applies mainly to much broader disease groupings for statistical purposes. Thus, one code number in the International list may be used to represent 20 or more conditions classified and coded separately in the *Standard Nomenclature*.

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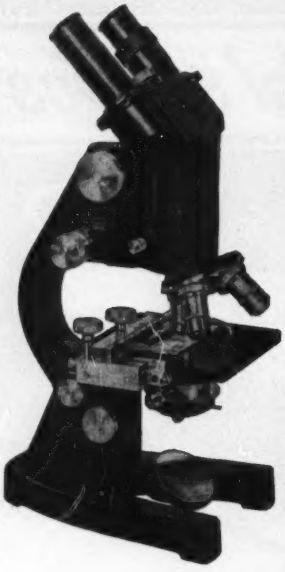
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Notes About People

(Concluded from page 52)

assumed his duties recently. Born and educated in England, Mr. Corner came to Canada in 1930, where he joined the staff of the Royal Victoria Hospital, Montreal. During World War II, he was an administrative officer in the Royal Canadian Air Force. In 1950, Mr. Corner was appointed assistant administrator at St. Mary's Hospital, Montreal, a post he held until his recent appointment.

* * * *

Dr. Jean F. Webb Appointed Paediatric Consultant

Dr. Jean F. Webb, Saint John, N.B., has been appointed by the Civil Service Commission as a paediatric consultant on the staff of the child and maternal health division of the federal health department. Dr. Webb holds degrees in science from Acadia University, in medicine from McGill University, and in public health from the University of Toronto.

Prior to joining the federal civil service, Dr. Webb spent two and a half years at the Harvard University School of Public Health where she was a research fellow for a time and, later, an instructor for a year and a physician in the child health division of the Boston Children's Hospital. She also received training in paediatrics at the Hospital for Sick Children, Toronto. Before going to the United States, Dr. Webb was director of nutrition services for New Brunswick's Department of Health and Social Service, for three years.

* * * *

Veteran Hospital Worker Completes Forty Years of Service

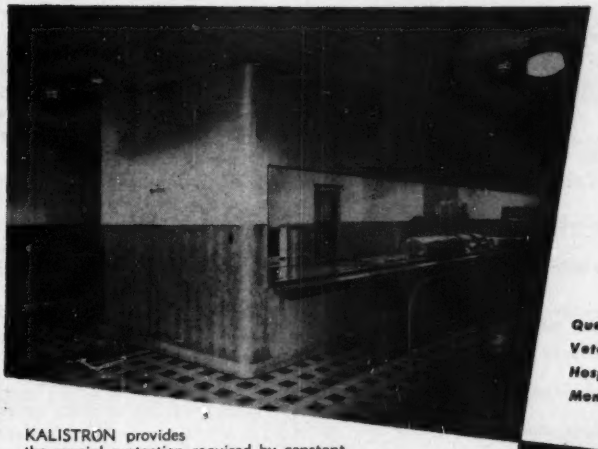
Mrs. J. B. Smith, veteran hospital worker, recently completed forty years of service to the Chatham Public General Hospital, Chatham, Ont. In 1910, Mrs. Smith joined the Ladies Assisting Society and, later, became a member of the Heather Society, another of the hospital's affiliated groups. She held many executive offices and was president of the Heather Society for sixteen consecutive years. Twenty-five years ago, she was appointed to the board of trustees of the Chatham Public General Hospital and, in years of service, she has the distinction of being one of the oldest members. The Women's Hospital Auxiliary Association, Province of Ontario, recognized Mrs. Smith's outstanding contribution to hospital work and appointed her, a few years ago, to act on the provincial advisory board, an office which she still holds.

True Satisfaction

Complacency and self-satisfaction are dangerous traits. They cannot possibly lead to that sharp vision of higher and better things which is the mark and symbol of leaders. They mean, when we see them in a man, that he is content to flounder along on last year's or last century's knowledge, looking over his glasses severely and saying "no" automatically to everything new. He is a negative person in whose way of life there is nothing to hope for but only deterioration and destruction.

If there is one point worth remembering more than another, both by the aspiring young executive and by the man who has been through the mill, it is this: the successful business leader gets more satisfaction from doing a job than from contemplating the finished product. Far more real than completion and ease and prestige is the stimulation that arises from the sense of accomplishment. It is not a "game", as some like to call it, but a way of behaving and thinking that the executive finds rewarding and in which he believes.

As to the executive's long view of his life and the purpose of it, he must have a certain idealism, a vision of what might be. He needs an honest purpose, founded on a just estimate of himself, and steady obedience to the rule of life which he has decided is right for him. He will, of course, have a sense of the perpetually unattained. He must be always trying. But so long as he succeeds in being every day just what he wants people to think he is on that day, he is perpetually attaining.—*"The Royal Bank of Canada Monthly Letter"*.



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Feb. 18-19—Sectional Meeting of the American College of Surgeons, Quebec City, P.Q.

Mar. 31-Apr. 1—Sectional Meeting of the American College of Surgeons, Vancouver, B.C.

May 16-17—Sectional Meeting of the American College of Surgeons, Toronto, Ont.

May 18-21—Annual Convention of the Canadian Society of Laboratory Technologists, General Brock Hotel, Niagara Falls, Ont.

June 1-6—Biennial Meeting of the Canadian Nurses' Association, Chateau Frontenac, Quebec City, P.Q.

June 10-12—Canadian Dietetic Association Convention, University of British Columbia, Vancouver, B.C.

June 15-18—Canadian Public Health Association, Fort Garry Hotel, Winnipeg, Man.

June 16-20—Western Canada Institute for Hospital Administrators and Trustees, University of British Columbia, Vancouver, B.C.

Oct. 8-9—Saskatchewan Hospital Association Convention, Bessborough Hotel, Saskatoon.

Oct. 16-18—Associated Hospitals of Alberta Convention, Palliser Hotel, Calgary.

Oct. 22-24—Associated Hospitals of Manitoba Convention, Royal Alexandra Hotel, Winnipeg.

Oct. 27-29—Ontario Hospital Association Convention, Royal York Hotel, Toronto.

Canada Year Book, 1951

The 1951 edition of the *Canada Year Book* is now available and can be obtained from the King's Printer, Ottawa. The price of the Year Book is $3.00 in the cloth-bound edition and $1.50 in the paper-bound edition. A limited number of the latter has been set aside for ministers of religion, *bona fide* students, and school teachers. Applications with remittances for these paper-bound copies must be forwarded to the Dominion Statistician, Dominion Bureau of Statistics, Ottawa.

A wealth of information is always available in the *Canada Year Book* and the volume contains chapters which cover such topics as population, education and research, and public health, welfare, and income security. Included among the special articles is a section on the conversion program to 60-cycle power in Southern Ontario. This book is, indeed, a valuable addition to any hospital library.



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L-Lysine	1.6	7.2
L-Threonine	1.0	5.2
L-Valine	1.6	4.0
L-Methionine	2.2	2.6 plus Cystine, 2.2 Gm.
L-Leucine	2.2	6.4
L-Isoleucine	1.4	4.0

1. Rose, W. C. (1949), Amino Acid Requirements of Man, Federation Proc. 8:546, June.

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Hospital Personnel Institute At Regina and Saskatoon

An Institute for hospital administrative personnel was held in Regina on November 27th and 28th, and in Saskatoon on December 6th and 7th. This program was presented by the joint effort of the Saskatchewan Hospital Association, the Saskatchewan Registered Nurses' Association and the Saskatchewan Department of Public Health.

This unusual co-operative effort was financed largely by funds from the Dominion professional training grant, although Saskatchewan hospitals contributed to expense allowances for staff members attending. The grant funds paid for lecturers, meeting-places, and a flat-rate travelling allowance for each person attending the Institute.

The program was designed for the trustees, secretary-treasurers, secretary-managers, and nurse superintendents of the small hospitals of Saskatchewan. Herbert Bassett of Prince Albert, President of the Saskatchewan Hospital Association, and Chairman of the Institute, reported that 86 people, representing 65 hospitals, and eleven public health workers, attended. These people felt the institutes had been very helpful and many suggested that the program should be extended to three days.

Hospital representatives attending made several recommendations regarding in-service training of hospital employees. These will be presented to the Saskatchewan Hospital Association.

Lecturers and conductors of seminars were: Dr. H. E. Baird, superintendent, Regina General Hospital; J. E. Friesen, chairman, Swift Current Union Hospital Board; S. N. Wynn, chairman, Yorkton General Hospital Board; H. Hall, chairman, Shaunavon Union Hospital Board; L. T. Muirhead, superintendent, Saskatoon City Hospital; Mr. Kushnir, superintendent, Canora Union Hospital; Miss M. M. Tennent, superintendent, Melfort Union Hospital; E. V. Wahn, superintendent, Swift Current Union Hospital; Miss Lola Wilson, Registrar, Saskatchewan Registered Nurses' Association; R. E. Tiffin, Provincial Fire Commissioner; Cpl. Mann, Criminal Investigation Branch, R.C.M.P.; and the following members of the provincial department of public health: Dr. G. W. Peacock, Miss I. Baldwin, J. C. Lee, J. E. Robinson, and G. C. Stewart.

What Constitutes a Leader?

A leader is not one who achieves by his personal powers but one who inspires all those under his command. Morale is the child of good leadership. Men work best for the executive who holds his beliefs with confidence, who will stand up on Wednesday for the principle he believed in on Monday. The executive needs inner harmony which shows itself in judgments based upon sound thinking and in his whole attitude toward his business and society.—*"The Royal Bank of Canada Monthly Letter", October 1951.*

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2) Introduces the required amount of mercury into the bag.
3) Aspirates the air from the balloon to reduce its bulk and permit easier introduction through the nasopharynx.

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Reference: Diamond and Abelson, *J. Lab. & Clin. Med.*, *30*, 3, 1945.



Hinged joints permit rocking.

Diet Therapy

(Concluded from page 46)

normal vigor. Then he prepared the same diet in a bulky form that took them most of the day to eat. After a few days, they came to consume all this ration but spent most of their time doing it. All the guinea pigs lost weight and continued to lose. Next he prepared the same diet, calories and all, and fed it in a concentrated form so that they could consume it in twenty minutes, once a day. Amazingly enough, they all gained weight. The essence of this experiment is that on a given, ordinary balanced, diet these pigs maintained weight; on a bulky diet of the same basic content, they lost weight, and on a concentrated form of the same diet, rapidly consumed, they gained weight.

Nearly all fat people claim they eat but very little. Often this is just a cup of coffee and a cigarette for breakfast, scarcely much more for lunch, and then a full dinner at night. This they consume rapidly and are finished before others have scarcely begun. This can be observed in any restaurant. Usually the fat person eats his food rapidly, and it is most unusual to see a thin person eat his food with promptness and gusto. They are often still picking after others have finished.

Translated into treatment terms this means, in severe anorexia, feed the person only what he can consume in twenty minutes once daily. The amount given should be all he can take in that time. For ordinary diets, the total calories should be about equally divided into three meals a day.

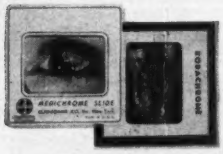
By the same deduction, reducing the fat person should be accomplished by feeding computed calories in three, if not four, bulky meals a day, all to be chewed slowly and well. Under no ordinary circumstance should a person on a reducing regime be allowed to eat his caloric requirements in less than three meals a day.

It really amounts to—grow fat on one meal a day; grow thin on four. Let me here testify that these measures are effective in managing patients.

From a purely medical viewpoint, I have tried to review a part of the rationale behind some of the peculiar demands that doctors make on the dietitian's time and experience. I hope it has helped a little to have you see with me the necessity of these measures in health and disease. If that has been true it will also bring home to you the importance of your role as dietitians in not only maintaining a healthy people but also in rehabilitating those who have been ill.

Newsletter

FOR THE MEDICAL AND BIOLOGICAL SCIENCES
Number 7 of a Series



Newest Teaching Aids for laboratory technicians, medical students and nurses: Clay-Adams' extensive MEDICHROME series of 2" x 2" Kodachrome lantern slides. These slides graphically present, at low cost and a minimum of equipment, a wide variety of normal and pathological conditions in the various medical specialties. Of particular value in laboratory instruction are the following series:

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Ommission

Page 26 of our December issue was enhanced by a photograph of a beautiful Christmas crèche and, inadvertently, the courtesy line was omitted. The picture came to us through the kindness of Sister Francis Eleanor of the Halifax Infirmary, Halifax, N.S.

Maritime Institute

(Concluded from page 48)

faced by a target area. Col. A. B. DeWolfe, provincial co-ordinator of civil defence in Nova Scotia, and Dr. G. Graham Simms, civil defence health director for Nova Scotia, led a discussion on this topic, Dr. K. C. Charron, Civil Defence Health Planning Group, Department of National Health and Welfare, Ottawa, related civil defence health services to the total civil defence organization and discussed the role of hospitals in target areas, mutual aid areas, and the reception and mobile support areas.

Sister M. Clarissa, administrator, St. Rita's Hospital, Sydney, N.S., spoke on "Nursing Staff Personnel Policies". Leaders of the discussion which followed were: Hilda Bartsch, Reg. N. superintendent, Charlotte County Hospital, St. Stephen, N.B., and Maizie Miller, Reg. N., superintendent of nurses, Victoria General Hospital, Halifax.

An address on "The Responsibility of the Trustee to the Hospital", delivered by Dr. Warren F. Cook, executive director of the New England Deaconess Hospital, Boston, Mass., opened the Friday morning session. Donald G. Grant, president, board of trustees, Children's Hospital, Halifax, spoke on "The Responsibility of the Community to the Hospital."

Featured in the afternoon session was the subject "Hospital Housekeeping and Laundry Management", which was discussed by G. J. Bartel, administrator, St. Mary's Hospital, Montreal. The closing session on Saturday morning was given over to a discussion on "Precautionary Techniques in General Hospitals" by Dr. Edward M. Fogo, director of Communicable Disease Control, Halifax, and a paper on "The Art of Nursing" delivered by Miss E. A. Electa MacLennan, M.A., Reg. N., Director, Dalhousie University School of Nursing.

Round table discussions and field trips to visit various departments in the Halifax Infirmary, the Victoria General Hospital, and the Camp Hill Hospital, supplemented the informative material which was presented in the lectures. The institute closed with the presentation of certificates by the A.C.H.A. representative, Dr. Warren F. Cook.

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Calgary Provincial Guidance Clinic Aided by Federal Grants

The federal government has earmarked funds from its health grants to help provide additional facilities for the expanding work of the provincial guidance clinic in Calgary. Established in 1947, the Calgary clinic has been gradually extending its services until it now reaches about 15 centres in the southern part of Alberta. Its staff provides diagnostic and treatment services for both adults and children showing early or severe signs of mental maladjustment.

The grant of more than $3,200 is to be used to buy equipment for play therapy for children, materials used for psychological testing of very young children, certain medical equipment, reference books and journals for the clinic's library, and films and printed matter to be used in public education regarding mental health. Part of the grant will be used toward the salary of an additional stenographer-clerk.

HELP WANTED MALE OR FEMALE

THE BRITISH COLUMBIA CIVIL SERVICE REQUIRES A HOSPITAL INSPECTOR AND CONSULTANT for the B.C. Hospital Insurance Service, Victoria, B.C. **Salary:** $308. rising to $358. per month, including Cost-of Living Bonus. **Duties**—will include inspection of hospitals and preparation of reports and recommendations relative to hospital practices and procedures; to provide consultative services in hospital administration, particularly to smaller hospitals; to undertake special surveys and investigations as required. **Qualifications**—High School graduation or equivalent; knowledge of administration of smaller hospitals, knowledge of elementary accounting; wide experience in related work including administrative experience in a smaller hospital; ability to meet and deal with hospital officials. Candidates must be British subjects, not over 40 years of age, for women, and not over 45 for men, except in the case of ex-service personnel who are given preference. Application Forms, obtainable from the B.C. Civil Service Commission, 609 Broughton Street, Victoria, or the Civil Service Commission, 636 Burrard Street, Vancouver 1, B.C., to be completed and returned to the Chairman, Civil Service Commission, Victoria, **NOT LATER THAN JANUARY 23rd, 1952.**

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Medium-sized hospital with Nurses Training School, requires DIRECTOR OF NURSING, university training desirable but not necessary. Full maintenance and private apartment provided. Write Superintendent, Memorial Hospital, St. Thomas, Ontario, outlining qualifications, salary expected. Personal interview to be arranged immediately following receipt of application.

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F. G. Moore

FRED MARSHALL MEDHURST, the Managing Director of T. J. Smith and Nephew Limited, Hull, England and of the Yorkshire Group of Smith and Nephew Associated Companies of London, England, is visiting Canada and the United States on an inspection tour of their North American interests and to promote dollar exports from the United Kingdom.

Frank G. Moore, Managing Director of the Herts Pharmaceuticals Limited, of Welwyn Garden City, Hertfordshire, England, recently acquired by Smith and Nephew Associated Companies, is also in Canada to review the present and future activities of Nivea Pharmaceuticals Limited, of Toronto, the Canadian subsidiary of Herts Pharmaceuticals Ltd.

Nivea Pharmaceuticals Limited now becomes a sister company of Smith and Nephew Limited, Montreal, and in the near future the selling and distribution of Nivea Products will be undertaken by —

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"Operation Hebron" a Mercy Flight

In these days of ice and snow, a mercy flight accomplished under hazardous flying conditions is always a story of excitement and courage. On December 7th, Hebron, Labrador was the setting for such a rescue with the central figure a 26 year-old Eskimo suffering from a shattered arm — the result of a gunshot accident.

For fourteen days the wounded Eskimo awaited evacuation to hospital, attended during this period by a Moravian medical missionary, the Reverend Grubb.

Intensive joint efforts to carry out his evacuation were made by officials of the public health department, the R.C.A.F. and U.S.A.F. An initial attempt to effect rescue by plane was thwarted by weather conditions. At that time (a brief season when flying to northern out-posts is not feasible) there was not enough snow to permit a landing on skiis and because of slob ice—small cakes of floating ice—a landing on pontoons was extremely dangerous. A U.S. weather ship in the North Atlantic was alerted but also was unable to be of assistance; and a scheme to rescue the wounded man by helicopter was likewise abandoned.

Rescue when it came was dramatic and unexpected. An R.C.A.F. amphibious Canso aircraft, piloted by F/L. L. B. (Mike) Pearson of the 103 Search and Rescue Detachment at Torbay, Nfld., had been directed on a mercy flight to Hopedale, Labrador, where a girl suffering from a broken leg, awaited evacuation to hospital. Learning that the girl had been rescued by helicopter, the pilot decided to proceed to Hebron. Landing conditions here proved to be extremely hazardous due to a low ceiling, floating ice, and a skimpy-sized landing run. To ascertain how badly the Eskimo needed medical treatment, the pilot dropped a portable radio set. When he was advised that the need was extreme, he decided to go ahead with the rescue attempt, after arranging to have a boat stand by with the patient aboard.

With courage and flying skill, F/L Pearson then proceeded to bring his plane down in a "semi-stall" landing. With the patient safely aboard, he made a successful take-off using "JATO" (jet-assisted take-off), necessitated by the ice conditions and a running swell. Airborne, once again, he flew directly to Goose Bay where the patient received emergency treatment. Danger did not end there, however. In flying the wounded man to hospital at St. John's, Nfld., the pilot ran into thick, pea-soup fog which had grounded other aircraft. After circling the airport at Torbay, he was forced to fly on to the U.S. base at Argentia where he finally brought his plane down safely.

Thus another mercy flight was successfully accomplished by F/L Pearson of Woodstock, Ont., who just recently had been decorated with the Air Force Cross for carrying out a similar mission to Ungava Bay last year. Co-pilot on "Operation Hebron" was F/O Gordie Grant of Toronto, and the R.C.A.F. nursing sister on the flight was F/O M. M. Kennedy of Sudbury, Ont.

A.C.S. Sectional Meeting, 1952

Again this year, the American College of Surgeons will continue the custom of holding a series of sectional meetings and an invitation to attend these meetings has been extended to all Canadians in the hospital field. The meetings will be held in various cities of the United States and Canada and a hospital conference is being arranged in connection with each meeting.

A schedule of the sectional meetings and the dates on which the hospital conferences will be held is as follows:

Feb. 4-5—Hotel Adolphus, Dallas, Texas.
Feb. 11-12—Chalfonte-Haddon Hall, Atlantic City, N.J.
Feb. 18-19—Chateau Frontenac, Quebec City, P.Q.
Mar. 24-25—The Radisson Hotel, Minneapolis, Minn.
Mar. 31-Apr. 1—Hotel Vancouver, Vancouver, B.C.
Apr. 7-8—Pioneer Hotel, Tucson, Arizona.
May 16-17—Royal York Hotel, Toronto, Ont.

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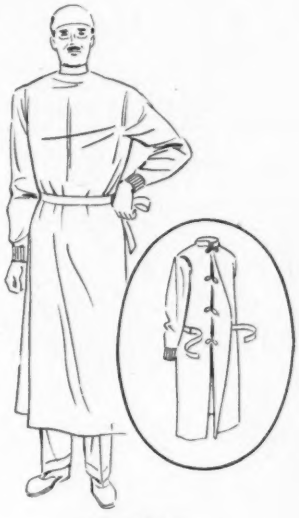
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